FEDERAL IMPLEMENTATION OF OBAMACARE: CONCERNS OF STATE GOVERNMENTS

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION AND REGULATORY AFFAIRS

AND THE

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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FEDERAL IMPLEMENTATION OF OBAMACARE: CONCERNS OF STATE GOVERNMENTS

Wednesday, September 18, 2013

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION & REGULATORY AFFAIRS, JOINT WITH THE SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittees met, pursuant to call, at 10:07 a.m., in Room 2154, Rayburn House Office Building, Hon. James Lankford [chairman of the Subcommittee on Energy Policy, Health Care and Entitlements] presiding.

Present from Subcommittee on Economic Growth, Job Creation & Regulatory Affairs: Representatives Jordan, Duncan, McHenry, Lummis, Bentivolio, Issa, Cartwright, Duckworth, Connolly, Pocan, Kelly, Horsford, and Cummings.

Present from Subcommittee on Energy Policy, Health Care and Entitlements: Representatives Lankford, McHenry, Jordan, Woodall, Massie, Issa, Speier, Cartwright, Duckworth, Cardenas, Horsford, Lujan Grisham, and Cummings.

Staff Present: Ali Ahmad, Majority Communications Advisor; Brian Blase, Majority Senior Professional Staff Member; Molly Boyl, Majority Senior Counsel and Parliamentarian; Lawrence J. Brady, Majority Staff Director; Daniel Bucheli, Majority Assistant Clerk; Caitlin Carroll, Majority Deputy Press Secretary; John Cuaderes, Majority Deputy Staff Director; Adam P. Fromm, Majority Director of Member Services and Committee Operations; Linda Good, Majority Chief Clerk; Meinan Goto, Majority Professional Staff Member; Frederick Hill, Majority Director of Communications and Senior Policy Advisor; Christopher Hixon, Majority Deputy Chief Counsel, Oversight; Michael R. Kiko, Majority Staff Assistant; Mark D. Marin, Majority Director of Oversight; Laura L. Rush, Majority Deputy Chief Clerk; Scott Schmidt, Majority Deputy Director of Digital Strategy; Sarah Vance, Majority Assistant Clerk; Rebecca Watkins, Majority Deputy Director of Communications; Jaron Bourke, Minority Director of Administration; Yvette Cravens, Minority Counsel; Jennifer Hoffman, Minority Press Communications Director; Adam Koshkin, Minority Research Assistant; Elisa LaNier, Minority Director of Operations; Una Lee, Minority Counsel; Dave Rapallo, Minority Staff Director; and Daniel Roberts, Minority Staff Assistant/Legislative Correspondent.

Mr. LANKFORD. The committee will come to order.

I want to begin this hearing by stating the Oversight Committee mission statement: We exist to secure two fundamental principles: first, Americans have the right to know that the money that Washington takes from them is well spent; second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights.

Our solemn responsibility is to hold Government accountable to taxpayers, because taxpayers have the right to know what they get from their Government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

In the past month I have personally spoken with a dad who told me that his high graduate son was having difficulty finding a job that will hire him for more than 29 hours; spoken with a mom that brought me her late 20-something son's insurance paperwork which notified him that his health premiums will increase from just over $200 a month to just over $800 a month starting in January; I talked to a family struggling with their family business because they cannot afford the mandates, but they also cannot afford to sell the business they worked so hard to build. High-risk pools that hit their max in March of this year, prevent anyone else from entering high-risk pools.

No one disputes that there were concerns with the U.S. health care system that predate Obamacare. Chief among those concerns was the rising cost of health care that was crowding out other items in family budgets and contributing to massive Federal budget deficits.

Obamacare was designed to fix three problems: reduce the cost of medicine, provide universal coverage for every American, and increase the quality of health care in America. Americans were told over and over again that if they liked their doctor and their insurance, they could keep them. After decades of work, union members are furious at the changes of health benefits and the traditional 40-hour work week.

While the law passed by Congress three years ago, implementation of the law has been mired in one problem after another and, according to a report by the Congressional Research Service, the Administration has missed approximately half of Obamacare's required deadlines. A recent GAO report on State progress with exchanges found that compressed time frames and a lack of clear Federal requirements related to the Federal data service's hub has a major IT challenge to opening the exchanges for enrollment October the 1st of this year.

Two months ago the Administration delayed Obamacare's employer mandate and several reporting requirements. Although I believe the employer mandate is bad policy, the effect of this unilateral delay by the Administration will be that the exchanges will have more difficulties verifying whether individuals have an offer of coverage at work, thus exposing taxpayers to the risk of significant spending on subsidies for those not qualified to receive them and, for those individuals that have received them, a tax burden at the end of the year that will be quite a surprise to them.

Moreover, the Administration only delayed the employer mandate. Individual citizens are still liable for the penalties; just businesses are no longer liable.

State leaders from across the Country have complained that the Administration has not adequately responded to their questions and concerns. Since many States have part-time legislatures that are only in session during the spring, HHS's failure to issue timely guidance harms States' abilities to implement the law and better protect its citizens from its harmful aspects.

Today we are pleased to hear the testimony from multiple State officials involved in much of the day-to-day work in preparing their respective States for the start of Obamacare. We have with us today multiple different witnesses. I will allow Ms. Speier to introduce some of those, but the Lieutenant Governor of Kansas, Jeff Colyer, who is also a physician; Florida State Representative Matthew Hudson; Secretary of the Department of Health and Hospitals from the State of Louisiana, Kathy Kliebert; and Attorney General for the State of South Carolina, Alan Wilson.

Yesterday the Democrats on this committee threatened not to participate in the hearing unless we invited eight Democrat-selected witnesses. Since normally the minority party only selects one witness, and even the majority party only had four witnesses for this hearing, it seemed like a fairly audacious request. But we didn't want members of this committee, that is formed to do oversight work, to walk out and fail to hear the serious struggles that States are experiencing as a result of Obamacare and the Administration's implementation of Obamacare, so we made the unprecedented accommodation to let them invite the same number of witnesses as the Majority. Members shouldn't walk away from States struggling to implement Obamacare. We should listen to their concerns and we should find solutions.

One area that will be explored today is the Administration's Navigator and Assistor Programs. One of the witnesses here today, Attorney General Wilson, from South Carolina, along with 12 other attorneys general, sent a letter to Secretary Sebelius on August the 14th asking questions about the Navigator Outreach Program. As is the pattern of late, the Administration has not yet responded. In fact, I spoke yesterday with health care leaders in my own State, and they informed me that they cannot get answers from HHS. The navigators they speak to my in State still have no idea what is happening, and we are only days away from October the 1st, that launch date.

Fortunately, the committee has conducted oversight of the Navigator and Assistor Program. I would like to introduce into the record a preliminary staff report on our findings relating to the Navigator and Assistor Programs. These findings were largely based on transcribed interviews with top HHS officials and internal HHS documents produced to the committee. The report shows that the Navigator and Assistor Programs are rife with mismanagement and they are still struggling to be able to put things together even at this point, and it has the real possibility that a large number of Americans will fall victim to fraud and identity theft.

Top HHS officials admitted that the Administration failed to conduct any analysis about whether or not it should require all indi-

viduals hired by Navigator and Assistor organizations to pass a background check or be fingerprinted, or have the same basic requirements that census workers have.

The Administration decided to leave the responsibility for authenticating navigators and assistors to the organizations receiving the grants to implement the programs. As a result, the Federal Government will not be able to provide consumers with a list of individuals officially certified as navigators and assistors. HHS officials deemed several marketing activities inappropriate, such as door-to-door solicitation and direct phone calls, but have not taken steps to ban them. HHS allows Navigator and Assistor organizations to pay their employees based on the number of individuals they enroll, which creates an incentive for those employees to provide biased or incomplete information about Obamacare to maximize employment.

We have multiple issues here. Every program in the Federal Government needs oversight. That should also apply to the newest programs in Government, like Obamacare. While billions are spent, it is reasonable to ask if it is going well and accomplishing what it was designed to do.

I now recognize the distinguished ranking member, the gentlelady from California, Ms. Speier, for her opening statement.

Ms. SPEIER. Mr. Chairman, thank you for the opportunity to comment on this hearing. Let me be frank. This is not a hearing; this is theater. I wish it was just a little bit more entertaining.

This is a bad script with a bad ending because some of my colleagues on the other side didn't like the way the presidential election turned out, didn't like the Supreme Court, including Chief Justice Roberts, finding law to be constitutional, and are simply desperate to rewrite the play.

It is time to take the makeup and the costumes off and get real. The Affordable Care Act is the law of the land, and there will be no rewrites, no matter how much you would like to rewrite the ending.

I am sickened by the efforts of some to sabotage this law at every turn. In some States the elected officials aren't even subtle about it. They don't even try to mask their blatantly political shenanigans under the guise of public interest.

Take the duly elected insurance commissioner of Georgia, who was caught on tape bragging to an audience of Republican campaign contributors and activists. Let's play the video.

[Video played.]

Ms. SPEIER. He said he was doing everything in his power to be an obstructionist. He pointed to the example of the Georgia Republican Legislature, which invented a new requirement that Obamacare navigators be licensed. His insurance department would just make up a test requiring navigators to pass the insurance agent's test just to obstruct them from conducting outreach to uninsured people.

The only justification for this new requirement is that it helps obstruct implementation of Obamacare.

Unfortunately, he is not alone. The only witnesses the Majority chose to invite are, like the Georgia commissioner, doing everything in their power to be obstructionist.

Florida State Representative Matt Hudson, we thank you for being here, is no particular expert on State concerns about the ACA implementation. Mr. Hudson is himself busy creating concerns and barriers to implementation. Recently he introduced a bill suggested in the State legislator's guide to repealing Obamacare. The poster is behind me, which was published by the American Legislative Exchange Council, ALEC, a Koch brothers-funded entity.

Not every Republican tolerates the obstructionist tactics. In Kansas, the elected insurance commissioner, Sandy Praeger, has struggled to implement the Affordable Care Act, even as Governor Brownback sued to challenge the constitutionality of the Affordable Care Act, returned a $32 million federal grant to help the State set up health insurance exchanges, and has called the Affordable Care Act an abomination.

Senators McCain and Coburn have both criticized their Republican colleagues for working to bring on a Federal Government shutdown just to stop the funding for ACA implementation. Senator Coburn called it "dishonest."

Sadly, this is a concerted campaign to deny people affordable health care being conducted by certain Republican elected officials, but it is being orchestrated by entities like ALEC and financed by billionaires like the Koch brothers.

I strongly believe in the importance of congressional oversight; it is our job to make sure that the laws of this land, laws passed by Congress, are carried out effectively and efficiently. But this committee is not engaging in oversight; it is not interested in getting to the facts and seeing the law properly implemented; or in identifying improvements or technical fixes. This committee has, instead, chosen to undermine the law and encourage the vowed obstructionists who are throwing hurdles in its way at every step of the process.

Mr. Chairman, this effort has become a theater of the absurd. While I appreciate that you have now accepted some of our witnesses to try and convince the audience that there is some semblance of balance to your script, your play will not make it to opening night and will be relegated to the dustbin of theatrical failures once the real show begins to run. I sincerely hope that this is the beginning of the end of the charade to undermine a law that has been found to be constitutional. And I would like to remind my colleagues that we are sworn to uphold the law and the Constitution, and that is a duty I take seriously. It is time we actually do our jobs.

I want to welcome Louisiana State Representative Katrina Jackson, Senator Brad Hutto of South Carolina, and Senator Eleanor Sobel of Florida. Thank you for joining us today and coming here on your own dime.

Mr. LANKFORD. With that, I would like to recognize the chairman on the Subcommittee on Economic Growth, Mr. Jordan, for his opening statement.

Mr. JORDAN. Thank you, Mr. Chairman. Thank you for putting this important hearing together where we can hear from folks on the front line.

Let me just say, in response to the last statement, everyone in the Country knows this law is not ready. Yesterday, Warren Buffett said scrap the bill. Last week the AFL–CIO voted and said fix it or repeal it. Max Baucus, not Republican James Lankford, not Republican Jim Jordan, Max Baucus said it is a train wreck. Howard Dean said it is going to lead to rationing of care. Not exactly Republicans there.

James Hoffa said it is going to hurt working Americans, going to fundamentally change the 40-hour work week, which it will, and it is already doing that.

Even the President knows this bill needs delayed. That is why he delayed it for big business. We just want to say delay it for the rest of America.

I mean, it is unbelievable. It was unpopular when not one single Republican voted for it and Democrats passed the bill; it was unpopular then. It is even more unpopular now. This argument is unbelievable.

I don't know that the Democrats have introduced a bill to fund the Government. There have been bills introduced by Republicans to fund the Government and delay Obamacare, which is exactly what the American people want. And we are going to hear from people on the front line today who know how hard it is to try to implement this legislation.

In Ohio, think about this. Last week, headline in an Ohio paper, in Ohio, seventh largest State, 11 million people. Not one single navigator, not one, has been trained and licensed as our law requires by the Ohio Department of Insurance. Not one. And we are 13 days away from the exchange starting. Not one. Seventh largest State; 11 million people. You think this thing is going to work well? You don't think this thing needs delayed? This is unbelievable. Of course it needs delayed, and the American people understand that, and they are just asking their representatives, Republican and Democrats, to recognize that fundamental fact. And this hearing is about highlighting that fundamental fact.

I didn't read my statement; I just reacted to what we heard before. But this is as clear as it gets. In my time in public life, I have never seen something this obvious, make this much common sense, and have that much opposition to doing it. Unbelievable.

Mr. Chairman, I yield back.

Mr. LANKFORD. Recognize the ranking member of the Subcommittee on Economic Growth, Mr. Cartwright, for his opening statement.

Mr. CARTWRIGHT. Thank you, Chairman Jordan and Lankford for calling this hearing.

All across this Country some State legislators and other elected officials are obstructing the Affordable Care Act law, the law of the land, and undermining enrollment in health exchanges. Just this week Florida Governor Rick Scott issued a directive banning Navigator grantees from operating on the grounds of county health departments. This is particularly obstructive because county health departments are precisely where Floridians with questions about the health care exchanges might turn.

Florida Governor Scott also stripped Florida's insurance commissioner of its ability to review insurance rates and protect con-

sumers from unfair or excessive premium hikes. The "rate review" provisions of the Affordable Care Act require insurance companies to justify any proposed health insurance premium increase of 10 percent or more. Last year, this provision alone saved 6.8 million consumers an estimated $1.2 billion in health insurance premiums. This is working.

In fact, every witness invited by the Majority here today represents a State government that is openly obstructing implementation of our Affordable Care Act. These witnesses do not have concerns about implementation, they are creating concerns and barriers to implementation, and they are proud of it. One witness, State Attorney General Alan Wilson, works under South Carolina Governor Nikki Haley, who said, "When it came to Obamacare, we didn't just say no, we said never. We are not expanding Medicaid just because President Obama thinks we should, and we are going to keep on fighting until we get people like Senator Tim Scott and everybody else in Congress to de-fund Obamacare."

Another witness, Secretary of the Department of Health and Hospitals, Kathy Kliebert, works under Louisiana Governor Bobby Jindal, who said, "We don't think it makes any sense to implement Obamacare in Louisiana. We are going to do what we can to fight."

Our constituents deserve better than this. One such constituent is right here with us today, Stacy Ritter, a resident of Pennsylvania, my home State. Stacy, if you are here, would you stand up? There she is. Welcome, Stacy. She came here on her own dime, she is here on her own expense, and she is here to tell you, either on or off the record, her compelling story, but I will tell you what it is right here. It is in her written statement. Unfortunately, the Majority has not allowed Stacy Ritter here to present her statement, but I am going to read an excerpt.

Mr. ISSA. Would the gentleman yield? I suspect I am the Majority. We have an unprecedented number of witnesses here from the Minority; three, when the tradition is one, and they were selected by the Minority, not by the Majority. So there are four witnesses that we selected. The ranking member sent me a letter yesterday asking for an additional eight, but in order to get them all on one panel, we have the largest panel we ever have, and all three of these witnesses were selected by the Minority. So I hope the gentleman was mistaken in that portion of the statement.

Mr. CARTWRIGHT. Reclaiming my time.

Here is what Stacy had to say: "Thanks to the ACA, the girls"—she is talking about her two daughters. She has two daughters with a rare blood disorder known as myelodysplastic syndrome. What she said was, "Thanks to the ACA, the girls can no longer be discriminated against if I were to lose or change jobs. Thanks to the ACA, we no longer worry about reaching lifetime caps on coverage. Thanks to the ACA, my girls can remain on my insurance until they are 26 years old, giving them time to finish college and find a job.

There are millions of Americans like Stacy Ritter who have needed the Affordable Care Act for a very long time.

Mr. Chairman, I am going to ask permission to insert Stacy Ritter's entire statement into the record.

Mr. LANKFORD. Without objection.

Mr. CARTWRIGHT. Now, in fact, in 2007, nearly 10 percent of Pennsylvanians reported they were unable to see a doctor when necessary due to the cost. Between 2003 and 2009, families in Pennsylvania saw their health insurance premiums increase by 45 percent, to an average annual cost of $13,229. Single policyholders experienced a 38 percent increase over the same period. Of those who do have health insurance, 53 percent are covered through their employment. Public programs such as Medicaid and Medicare insure 31 percent of Pennsylvania's population, and 5 percent of residents purchase individual private policies. This leaves nearly 1.4 million, 11 percent of the State's population uninsured for health care.

Pennsylvania's children are uninsured at a rate of 8 percent. This is a figure that doubles to 16 percent for children living in households with incomes less than 139 percent of the Federal poverty level. Non-elderly adults, those younger than 65, that live in these lower income homes, are uninsured at a rate of 32 percent. A quarter of Pennsylvania's non-elderly Hispanic population lacks health insurance, non-elderly Blacks are uninsured at a rate of 17 percent and 11 percent of the non-elderly white population is uninsured.

Over the next six months, as the health exchanges stand up, Pennsylvanians like Stacy Ritter will finally be able to get the help they need for themselves and their families.

Our job is to conduct oversight, and not cheer while State officials impede the implementation of enacted Federal law.

I yield back.

Mr. LANKFORD. I recognize the chairman of the full Committee, Chairman Issa, for his statement.

Mr. ISSA. Thank you, Mr. Chairman. I want to thank both our chairman and ranking members for holding this important hearing.

As I said earlier, we have a very large panel and I look forward to getting to that panel.

There is an old expression here in Washington: When asked about a tough situation, people will often say, well, some of my friends are for it and some of my friends are against it, and I want to be with my friends.

Now, I have never said let's de-fund and eliminate all of Obamacare without viable replacements for many of the things that the Affordable Health Care Act chose to do. Along with every Republican in Congress at the time, I voted against the Affordable Care Act because I felt there were many things in there that were overreaching and that were very lopsided. But let's understand that I think every member on the dais and every member testifying today would say there were problems in health care before President Obama came into office.

The Affordable Care Act attempted to say it was going to tackle many of those problems, and some of them we agree on: people with preexisting conditions finding themselves unable to leave a job; the unemployed college graduate or, for that matter, the returning veteran not eligible for retirement, but finding himself unemployed and out of the military, trying to figure out where he or she is going to go to get health care.

There are many, many groups that were falling through the safety net of predictable access to health care. We need to deal with that. Very clearly, America's problem is not that we don't have some of the best health care, it is that we have the most expensive health care. One of my concerns is that the Affordable Care Act does little to make it affordable except through subsidy. Attacking the real causes of our health care costing more than any other first world nation is something that we must work on.

Ms. Speier, who was very new when the Affordable Care Act was passed, said something today that I am taking some exception to, not on a personal basis, because I don't think she meant it, but she said that this law is the way it is and nothing is going to be changed. Well, bad law happens. The Affordable Care Act, for example, mandates that every member of Ms. Speier's staff and every staff member of everyone on this dais is to be thrown off of the Federal workforce's health care system, put into an exchange, and not reimbursed. In other words, the Affordable Health Care Act cut by $5,000 to $10,000 the benefit for people making as little as $25,000 or $30,000 a year, as staffers here on the Hill.

Now, I am sure Ms. Speier, if asked, would have said, well, I am not voting for that. But she did vote for it. It needs to be fixed. We cannot have the men and women who would like to serve members of Congress find themselves working for a deadbeat employer. That is real; it is in the Act. It was in the Act from the Senate, so maybe we in the House can say we have to fix it. But it is there.

Now, in the Act is an implementation that has a lot of bureaucracy, including State exchanges. The anticipation was that all States would quickly come together and want to have State exchanges and want to have the subsidies that came with it. What I believe we have seen is a legitimate disagreement between States who do not want to have a limited subsidy that would probably be phased down or out and leave them holding the bag with all the regulations that come with a Federal program.

More importantly, this committee has held a series of hearings, and I thank both chairmen, on the implementation problems, databases, privacy and so on. These are not intended to kill an existing law; they are intended to make it clear that if it is to go into effect, it should go into effect at a time that it can be effective. Nothing will kill Obamacare faster than in fact a series of horrific mistakes, losses of private or sensitive information or denial of care, or, in fact, huge cost overruns.

So I, for one, am not one of those people who said I am going to kill Obamacare; I am going to, in a Machiavellian way, attempt to delay or deny. But as chairman of this committee, with my subcommittee chairmen, we have seen serious problems our witnesses will talk about. Hopefully, by putting all seven on this panel, we give an opportunity for people who have concerns about the implementation of the Affordable Care Act and those who believe that we are ready to go live in a matter of days to have an appropriate debate.

I am pleased and I thank the ranking member, when he made his selection, to choose people from responsible positions where they are looking at the Act, and not the benefits of the Act, but the

actual Act, and whether implementation will be done properly and on time.

I share with the chairman's opening statement that, in fact, if the President wants to delay one part of a mandate, Congress has to ask are we ready to go live.

Lastly, I think for all of us on the dais, we understand that some parts of the Affordable Care Act are already law, they are already implemented. It is a question of implementing these large, expensive programs with, for example, a database that has today not been tested, but in a matter of days is supposed to go live with all of your personal information transferred from the IRS and your health care information added to it on a daily basis. That is something we should be concerned with.

So I join with the ranking member in welcoming this large panel of distinguished individuals who do not agree on everything, but hopefully they will be my friends and agree that we have to get it right. And if that means, Ms. Speier, changing some parts of the law, so be it. Let's work together on making this an Affordable Care Act in every way we can while we debate whether or not we can afford some aspects of it.

Chairman, thank you for the indulgence. I yield back.

Mr. Lankford. Recognize the ranking member from the full Committee, Mr. Cummings, for his opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I was very heartened by the words of the chairman of the committee and I want to thank all of you for bringing us together today.

I want to remind all of us of something that we may have forgotten. This is the law. Hello, this is the law. It has been passed. Chief Judge Roberts of the Supreme Court said it was constitutional. It is the law. And every two years every member of this committee, we put our hands up and we say that we are going to uphold the law. That is where we start.

So I am so appreciative of what the chairman just said, but the 41 times that we have voted on this, it was not to replace it. No. It was to kill it. Period. To kill it. Forty-one times.

So I want to thank you, Mr. Chairman, for accepting the witnesses we requested. I want to thank the chairman of the committee. I thank you. They are elected officials from South Carolina, Florida, and Louisiana. After serving as speaker pro tem of the Maryland House, I want to thank all of you, and I appreciate your service.

Unlike the witnesses invited by the Majority, these officials have tried to implement the Affordable Care Act even in the face of obstruction coming directly from their own governors. Trying to implement the law. Unfortunately, there is a systematic effort by some Republican officials to obstruct implementation of the Affordable Care Act. These officials have openly, it is not a secret, come on now, pledged to fight implementation, harass entities attempting to conduct public education and outreach, and adopted legislative and regulatory maneuvers to sabotage the Affordable Care Act. That is a fact.

Last week, Chairman Upton sent letters to 51 State Navigator organizations demanding that these community organizations turn over huge amounts of documentation to the Committee on Energy

and Commerce. As Norm Ornstein said, "This is intimidation and another effort to sabotage." Not replacing anything. Not improving anything. Trying to kill it.

Some Republican State officials have taken a page from the same playbook. West Virginia's Attorney General Pat Morrisey recently sent letters to Navigator grantees in his State demanding answers to dozens of questions. One recipient, West Virginia Parent Training and Information, subsequently returned $365,000 in grant money that it had applied for and won. Other States are acting the same way.

The problem is that there are tens of millions of people who desperately need the Affordable Care Act to succeed, including in these very States. And as our witnesses testify, I want you to tell us what happens to them. What happens to the people in your States who are sick and cannot get care? And they need members of Congress to do our job and help it succeed through responsible oversight.

If I may, I would like to introduce Ms. Aqualine Laury. Ms. Laury, would you stand up? A resident of Virginia and the victim of a stroke she suffered in college, as well as a series of other serious health problems, Ms. Laury is here today on her own dime. Like millions of other Americans, she cares what insurance companies call a preexisting condition. And when the chairman talked about the good parts of law, one of the things that we have to keep in mind is that you have to have the whole law to make it work.

Mr. JORDAN. Would the gentleman yield?

Mr. CUMMINGS. No, I want to finish my statement. I want to talk about this lady who traveled here, who has been ill. Ms. Laury traveled here today to present her story to Congress.

This is her story: "In 2005, I decided to leave my job and a large employer to pursue my dream of owning my own business. However, later that year I needed emergency gallbladder surgery and suffered complications. At that point, my insurer rescinded my coverage and left me with $50,000 in medical bills during my first year in business. If the Affordable Care Act had been in place then, it would have been against the law for my insurer to drop me from coverage. I am looking forward to opening the health insurance marketplace in Virginia this October and the availability of the new health insurance premium tax credit that could potentially make my health insurance even more affordable. I am also very appreciative that I no longer have to worry ever again about being denied coverage due to my preexisting conditions, being charged exorbitant premiums that I can't afford, or having my coverage dropped if I need another hospital visit."

Ms. Laury, I want to thank you for coming. By telling us the story of your life, it is personal business, you speak for millions of Americans, millions.

And I ask that Ms. Laury's complete statement be entered in the record, Mr. Chairman.

Mr. LANKFORD. Without objection.

Mr. CUMMINGS. Thank you.

Mr. CUMMINGS. As I conclude, the truth is that nobody really believes today's hearing was intended to help make the Affordable Care Act work better.

Now, I must say that I believe the chairman meant what he said. But not everybody is where the chairman is. That is why we have had 41 votes to kill it. Republicans have taken more than 40 votes on the House floor to appeal Obamacare and replace it with absolutely nothing.

Everyone knows what this hearing is really about: trying to end Obamacare. This week House Republicans are threatening to shut down, shut down the entire Government unless the Affordable Act is completely de-funded. Republicans want to eliminate health coverage for tens of millions of Americans, return the keys to the insurance companies, and go back to the days of discrimination against people like Ms. Laury with preexisting conditions.

Ladies and gentlemen, I have said it before and I will say it again, we can do better. And the chairman is right, there are things that we can do to improve this. And this may be hard, but this is America. We do hard things all the time. We can do this because people's lives are dependent upon it.

With that, I yield back.

Mr. JORDAN. Mr. Chairman?

Mr. LANKFORD. Yes, sir.

Mr. JORDAN. Mr. Chairman, I just point out the gentleman talked about the law, implementing the whole law. Was the President upholding and implementing the whole law when he gave a delay to big business? Great speech. Give it to the President of the United States. He is the one who said big business gets a delay, but the rest of America doesn't.

Mr. CUMMINGS. Come on, now.

Mr. JORDAN. Well, that is the truth.

Mr. CUMMINGS. Mr. Chairman?

Mr. LANKFORD. Yes, sir.

Mr. CUMMINGS. He knows what the President was trying to do, was to try to——

Mr. JORDAN. The gentleman——

Mr. CUMMINGS. Are you going to let me answer the question?

Mr. JORDAN. You got seven minutes. I just took——

Mr. CUMMINGS. Why did you ask me a question?

Mr. LANKFORD. It is all right. Go ahead and answer the question, sir.

Mr. CUMMINGS. Yes. Again, this is hard and business said that they could not get certain things accomplished. The President gave them that leeway. A lot of the problem that we have in the law is because of things that happened when we were trying to pass it and trying to compromise here, compromise there. But, again, the chairman of the committee is right. You are right. There are things that could be better. But that does not mean we scrap it and throw it out, because people will die. They will literally die, and you know it.

Mr. JORDAN. The gentleman was making the fundamental point. He specifically said, and we can read it back, he specifically said the whole law. And I just want to know if it is the whole law, it should be the whole law, and we shouldn't give some special dispensation to big business, which the President did without even have Congress vote on it.

Mr. ISSA. Mr. Chairman?

Mr. LANKFORD. Sir.

Mr. ISSA. I take no special privilege, but as a member of the committee I know that we have witnesses who can deal with some of the challenges that everyone is concerned about, the individual mandate, the corporate mandate, the timeliness of it and so on. So I hope we can get to it.

I join with the ranking member in one sense: this is an important hearing. We will disagree on the purpose of it, perhaps, but I think that as we hear from our witnesses, both sets of witnesses, I think the witnesses will speak for the real intent of the hearing, and I look forward to getting to it and then a lively debate afterwards.

Mr. LANKFORD. We will have plenty of opportunity for that in the conversation as we try to determine how is the implementation going and what are the real effects on the ground.

With that, members will have seven days to submit opening statements for the record.

We will now recognize our first and only panel today.

The Honorable Jeff Colyer is the Lieutenant Governor of Kansas and also a physician.

Ms. SPEIER. Mr. Chairman, I have an inquiry.

Mr. LANKFORD. You have an inquiry?

Ms. SPEIER. Mr. Chairman, we normally swear in all of the witnesses. Are we not going to do that today?

Mr. LANKFORD. We are. We going to introduce all of them and then swear in.

Ms. SPEIER. Thank you.

Mr. LANKFORD. We can't have a good hearing without a good swearing in the middle of it as well.

[Laughter.]

Mr. LANKFORD. The Honorable Brad Hutto is a State senator from the State of South Carolina. The Honorable Alan Wilson is the Attorney General for the State of South Carolina. The Honorable Katrina Jackson is a State Representative for the State of Louisiana; Kathy Kliebert is the Secretary of the Department of Health and Hospitals for the State of Louisiana; the Honorable Eleanor Sobel is the State Senator for the State of Florida; and the Honorable Matthew Hudson is a State Representative for the State of Florida.

Pursuant to committee rules, all witnesses will be sworn in before they testify, and by Ms. Speier's demand as well. Just kidding. But we do ask you to rise, raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you, God?

[Witnesses respond in the affirmative.]

Mr. LANKFORD. You may be seated.

Let the record reflect all the witnesses have answered in the affirmative. Thank you for that.

In order to allow time for discussion, and we will have some good discussion with this, please limit your testimony to five minutes. You have a clock that is right in front of you that will start as soon as you begin. Please note, as well, we need you to be able to push your button to make your microphone live. When that is lit up and

it says talk, you are live on your microphone, and we will need you to get as close as we can to make sure that we can hear every syllable that you say from there.

With that, I would like to recognize our first person, Lieutenant Governor. Be honored to be able to receive your testimony.

WITNESS STATEMENTS

STATEMENT OF THE HONORABLE JEFF COLYER, M.D.

Dr. COLYER. Thank you, Mr. Chairman and ranking members. My name is Jeff Colyer. I am honored to be the lieutenant governor of Kansas. I am also a practicing physician who, every day, this past week, for example, has operated on people without insurance, and we take care of them every day. So this is something that is very personal to me.

Like most States, Kansas is facing problems with the Affordable Care Act. It is a drag on Kansas businesses. A July 2013 Gallup poll suggested that small business owners revealed that 41 percent of business owners said that they were going to hold off on plans to hire new employees because of the Affordable Care Act. And in Kansas that trend is no different. Wherever I go, the biggest concern I hear is the uncertainty about what the ACA is going to do to small businesses.

In a new development, since my testimony was written last week, it affects businesses such as mine. I am a sole practitioner. Just yesterday we had to sign a contract for $3400 to rewrite all of our compliance manuals to fit in with the ACA. All it does is continues the same HIPAA requirements that we had before, but we just have to have a new form of documentation of that. It is something that doesn't change what we do, but it certainly costs us from new equipment, new jobs, and from taking care of our patients. So I think you are going to see this everywhere in a lot of different places.

Another Kansan, named Mike Bergmeier, of Shield Agricultural Equipment in Hutchison, Kansas, said that he can't grow his company beyond the 44, 45 full-time employees because he needs to avoid the mandates that require companies with more than 50 employees to meet the ACA's requirements. Mr. Bergmeier's situation is not unique.

The Affordable Care Act is a drag on the economy like ice is on the wing of an airplane, preventing it from taking off. This is damaging to everyone, especially the middle class.

Now, there is some other issues on operability. One place is where the States and Federal Government interact to determine eligibility for Medicaid and for the individuals on the exchange. Our State is significantly advanced in doing that and we have a very good, very strong working relationship with CMS, and a very positive one. Now, as recently as September 6th I said in my testimony, but we have now heard on September 13th, there are a number of additional technical updates that keep disrupting the time completion for this. In fact, it appears that there is going to be an additional update coming up even before the October 1st deadline. So that is going to make it very difficult for every State to do that. We are doing our best that there is.

But then there is also this contradiction that is set up in determining eligibility. For Medicaid, Kansas and every other State they have to look at a person's real income and, if they don't verify that, we would lose Federal funding for our Medicaid program. It is very hard for the taxpayers to have confidence in a system where, on the exchanges, we have an honor system in the first year to verify income. So it is really a strong dichotomy that I think undermines a lot of confidence in the system.

Another issue that we have is dealing with the education and outreach by the Federal Government. Just recently is when the Navigator programs received their contracts. As yet, they are supposed to be set up in order to know how the system runs, and we just learned who are those navigators going to be just a few weeks ago, and yet the system is still not able to go live today so that they can even practice and be fully formed in that. Kansas has not passed a number of laws about the skill sets of the navigators or anything partly because we didn't have all of the regulations that had come down.

There is also an issue of rates. It is going to be very expensive for us. One of the things that is there is in the State of Kansas, our exchange is only going to have two insurers on the entire exchange. Two insurers. That is not more competition, that is less competition. In fact, in Kansas you have more choices in Medicaid than you do in the Federal exchange in the State of Kansas. So we have looked at a number of the price issues and things like that, and it is going to be a challenge for people.

Finally, as a physician, I see this every day. I visit with my colleagues; we work together. We serve the uninsured. We have done that before. I have been doing it for 20 years; we will continue to do it in the future. This is not going to solve those issues. This is not going to make health care more affordable. In fact, it sets up new bureaucracies like the $3400 that I have to spend just now. It doesn't make health care necessarily better.

We can do a much better, and it is best left to the States. Thank you.

[Prepared statement of Dr. Colyer follows:]

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Jeff Colyer, M.D., Lieutenant Governor

Sam Brownback, Governor

TESTIMONY BEFORE THE JOINT SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION AND REGULATORY AFFAIRS,
AND ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

September 18, 2013

Jeffrey Colyer, M.D.
Lieutenant Governor, Kansas

Good morning, Chairman Jordan, Chairman Lankford and members of the Subcommittees on Economic Growth and Health Care.

Thank you for holding this hearing on the concerns of state governments related to the federal implementation of the Affordable Care Act. My name is Dr. Jeff Colyer. I am a practicing physician, and I am honored to serve as the Lieutenant Governor of the state of Kansas.

There are several issues that affect states with the implementation of the Affordable Care Act in the short and long runs. Theoretically these issues should be less complex in Kansas than other states because Kansans have chosen not to expand Medicaid nor implement a state based exchange. Nevertheless the issues are profound and detrimental to our citizens.

UNCERTAINTY DRAGGING DOWN BUSINESS

Although we are told the entire law must be fully implemented to achieve its goals, the federal government is having significant problems and is delaying or modifying programs. This month, the Congressional Research Service reported that President Obama has already signed 14 laws that amend, cancel or otherwise change parts of his health care law, and most significantly, just this year his administration has taken five independent steps to delay significant provisions of the ACA on its own.[1] With a law of this size and scope, these haphazard changes are having a devastating effect on the confidence of citizens and businesses in our great state of Kansas, and across the country. And they obviously change the basis of the program.

Uncertainty caused by the Affordable Care Act is a drag on Kansas businesses. A 2012 Mercer study indicates more than sixty percent of small business owners expect ACA to raise their business's health care costs.[2] Similar research by the Gallup Organization echoes these findings. These higher health insurance costs are creating incentives for businesses to cut back and produce services and products with fewer workers. The July 2013 Gallup poll of small-business owners further reveals that forty-eight percent of business owners believe the Affordable Care Act will be bad for their business, while forty-one percent indicated that they have held off on plans to hire new employees.[3]

In Kansas, this trend is no different. Wherever I go, the biggest concern I hear is the uncertainty about what the law is going to do to small business. A Kansan named Mike Bergmeier recently testified to Congress about the challenges that all federal regulations have on his business. Mr. Bergmeier, President of Shield Agricultural Equipment in Hutchison, Kansas told the House Small Business Committee he will not grow his company beyond the 44 full time employees and 4-15 part time people he currently employs so as to avoid the mandates that apply to companies with 50 or more employees. Mr. Bergmeier's situation is not unique.

The inability of the Administration to project clearly and articulately how the law will affect small businesses is resulting in economic stagnation. Businesses are scared to invest in jobs, they're scared to invest in expansion, and they're scared to invest in Kansas' future. This is damaging to everyone, but felt most directly by the middle class.

The effect of the Affordable Care Act on the economy is like ice on the wing of an airplane preventing it from taking off. As stories like those told by Shield Agricultural Equipment play out thousands of times across the country, it is easy to understand why our economy refuses to

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[1] CRS memorandum to the Honorable Tom Coburn, September 5, 2013.

[2] Scott Shane, "Obamacare already shrinking small-business job growth" *Entrepreneur*, September 12, 2013.

[3] Dennis Jacobs, "Half of U.S. small businesses think health law bad for them" *Gallup:Economy*, May 10, 2013.

take off as it should.

INOPERABLE TIMELINE

One place where states and the federal government interact is in determining eligibility for Medicaid and the individuals on the exchange. In practical terms, this means that the state eligibility data platform must be interoperable with the federal eligibility system. This program has been a challenge to implement under the unreasonable timelines demanded by the law. While our state is significantly advanced in the process and has had a positive working relationship with the Centers for Medicare and Medicaid Services, we continue to face challenges. As recently as September 6, Kansas learned of technical updates that disrupted some of the critical preparation we had previously completed. As a result, countless resources and energy continue to be dedicated to evaluating the ever-changing landscape of ACA implementation. We must continually consider whether or not our timelines will match those of the federal government.

Even if the deadlines are met there is a significant contradiction in determining eligibility. For Medicaid, states must verify incomes or face loss of federal funds. On the other hand income eligibility for subsidies on the federal exchange apparently does not need to be verified with the same rigor. It is hard for the taxpayers to have confidence in a system where exchanges use an "honor system" to verify income for federally run programs while the states – appropriately – use much more stringent verification for Medicaid.

The lack of education and outreach by the federal government is disappointing. As a Federally Facilitated Marketplace, there is ambiguity on the state side because of the late date the federal government awarded navigator grants. This delay is forcing the navigators in Kansas to rapidly get up to speed, while the system they will be working with is not yet fully formed.

The delays prevented many states from enacting appropriate privacy laws and have to deal with issues relating to insurance brokers, navigators, and an apparently a new category of assistors.

GOVERNMENT ENFORCED RATES

Unlike the president and his team have promoted, Kansans will undoubtedly see rate hike and limited competition on the exchange. While most details of the exchange have not been released by the federal government, what we do know about rates is startling. A website recently launched by the Kansas Insurance Department, insureks.org, allows Kansans to estimate their premiums under the new marketplace. The website projects a typical 25 year old uninsured male Kansan in Douglas County with an income of $30,000 will have a premium of $163 per month. Further, this individual will only be able to choose between two companies. A similar

search on ehealthinsurance.com indicates this same young man could obtain insurance for $43 per month today with the option of choosing a higher cost plan should he want. But unlike today, the Kansan in this example will be required by their government to purchase the far more expensive product he may not want or need on January 1.

Lastly, as a physician, I speak with my colleagues in the medical community every day. To a person all have expressed concern that the law will significantly limit their capacity to practice best care. They don't understand how health outcomes can be improved by a law that drives healthcare decisions to be made from Washington rather than the cherished relationship between the doctor and patient.

Kansans and I believe most Americans know the best decisions are made closest to the people. If we repeal the ACA, we can make a health care system that provides better results, provides coverage for the vulnerable, and is affordable.

Mr. Chairman Lankford, Mr. Chairman Jordan, thank you both very much for the opportunity to visit with you today.

Mr. LANKFORD. Senator Hutto.

STATEMENT OF THE HONORABLE C. BRADLEY HUTTO

Mr. HUTTO. Thank you, Mr. Chairman. I thank the distinguished members for allowing me the opportunity to address the issue of the Affordable Care Act and how it will affect my rural South Carolina district.

The Affordable Care Act would allow 350,000 to 400,000 South Carolinians to obtain health coverage. With Medicaid expansion, an additional 200,000 South Carolina adults could be covered. It is appalling that some South Carolina officials continue to pursue efforts to block our citizens from receiving health care coverage.

I am pleased to be seated by our fine, hardworking attorney general from South Carolina, a friend of mine. Like me, he is privileged to be an elected official. But from his privileged place as an elected official and the child of an elected official, General Alan Wilson has enjoyed taxpayer subsidized health care for most of his life. He has never had to worry about having a doctor to see when he gets sick.

Yet, when it comes to allowing hundreds of thousands of South Carolinians to obtain much-needed health coverage, he willingly leads the opposition, without offering any constructive alternatives to their plight.

When I go back to the State Senate in January, I am going to be facing the first bill up, which is a Republican filed bill that will nullify Obamacare. In a chamber which is presided over by the portrait of John C. Calhoun, we are going to debate nullification in the South Carolina Senate.

We tried that in the middle 1800s. It didn't work out too well for us then, and it is not going to work out too well this time. What we are looking for is solutions, not roadblocks.

Without the expanded health care coverage from the Affordable Care Act, uninsured South Carolinians will continue to be relegated to emergency rooms across the State or to simply suffer in pain without basic care. Treatment in an emergency room for nonemergent conditions is the most inefficient and most expensive form of care. Expanded coverage can allow the newly insured to find a medical home where they can be diagnosed and treated for basic human health needs that do not require the attention of an emergency room. Medical homes will allow patient-focused preventative care such as coaching and counseling on nutrition, diet, and physical activity, a holistic approach which will lead to cost-effective health care.

It is shameful for us to live in the greatest Country in the world and yet have our citizens face the threat of bankruptcy merely because they got sick or injured. Economic ruin should not be the price of having a sick child. By having more of our citizens covered with comprehensive insurance, premiums should be lower. We look forward to a time when all of our citizens can enjoy the coverage that is enjoyed by General Wilson and myself. Some could be covered by expanding Medicaid, others by purchasing affordable coverage through the exchanges, and yet others through their employment. It is this inclusive approach that will allow all South Carolinians to be covered.

Full implementation of the Affordable Care Act will benefit taxpayers. Without expanded coverage, the cost of paying for treatment of the uninsured falls now on taxpayers and employers. South Carolinians have paid Federal taxes that can come home to South Carolina once the expansion is implemented. Once every one is covered, medical costs can be more easily controlled and premium rates should fall.

As more people have health care coverage, more providers are going to be needed. The expansion will result in an economic boost to South Carolina. The training of new providers will allow our technical colleges and our universities to grow. We have had a university-based research study done in our State that says that we can expect 44,000 new jobs from the full implementation of the ACA. The salaries from these employees and the expanded services will generate millions in annual earnings and ultimately new revenue for the State. This is in addition to the billions of dollars that will flow back to the State from the Federal Government over the next six years.

Health care in South Carolina is 20 percent of our economy. With over 1100 different occupations, health care sectors in our State employ 250 South Carolinians. These are good paying jobs, jobs built on caring for our neighbors. It is a vital part of our economic sector and these are jobs that cannot be outsourced

The Affordable Care Act is a huge net benefit not just to those with preexisting conditions, but to our taxpayers, our hospitals, our doctors, those who will be newly employed, and citizens who will see their premiums reduced. Quite simply, South Carolina needs to accept the benefits being extended to our citizens if for no other reason than it is the right thing to do. Thank you.

Mr. LANKFORD. Attorney General Wilson.

STATEMENT OF THE HONORABLE ALAN WILSON

Mr. WILSON. Thank you for this opportunity to address the committee. I want to deviate from my introduction briefly to say that several remarks were made that aren't accurate. Earlier, Representative Cartwright mentioned that I was under the governor, under Governor Haley. That is not accurate. I am an independently-elected official in South Carolina.

To my recollection, those comments or that quote that was attributed to me was not made by me. My opposition was presented in our briefs before the United States Supreme Court. As attorney general, I am not in the implementation process; I am here as an advocate for the consumers of South Carolina. Also, I am on government health care, as my good friend, Senator Hutto, said, but after 17 and a half years and a combat tour in Iraq, I believe I am entitled to be on TRICARE.

My testimony today has nothing to do with the merits of the Affordable Care Act; it has everything to do with the first obligation of government: the security and safety of the citizens, as well as sharing with Congress the need to indefinitely suspend implementation of the Affordable Care Act until security risks are mitigated, privacy protections are provided, and legally mandated deadlines are properly met.

Despite the President saying, last month, we are all on our way to fully implementing the Affordable Care Act, important deadlines are being routinely missed and, more importantly, security concerns are being dismissed. An unpublished Congressional Research Service meme cited by Forbes last month noted that the Administration has missed more than half the legally imposed implementation guidelines.

In order for the ACA to adequately determine eligibility of consumers for exchange subsidies, it must create a data hub that creates databases from seven different agencies.

Last week, Centers for Medicare and Medicaid Services confirmed the ACA's data hub complies with Federal Standards. However, the hub has not been beta-tested, independently verified, or properly audited by the inspector general. More troubling is the fact that senior HHS technology officials lowered previous standards earlier this year by saying let's just make sure it is not a third-world experience.

When it goes live on October 1, it may not be a third-world experience, but it will be a con man's all-you-can-eat buffet, overflowing with a gold mine of sensitive information from the agency databases that fall under the hub.

This information in the hub should be guarded as if it were gold in Fort Knox, not haphazardly. The hub should be at least required to exceed minimally adequate protocols which have allowed the records of more than 20 million veterans to be compromised during at least eight hacks of the VA's unencrypted computer system between 2010 and 2013.

States are also victims of similar attacks. Exactly one year ago, more than 3.6 million South Carolinians were put at risk when hackers obtained our social security numbers and personal information during a major security breach at the South Carolina Department of Revenue.

Such attacks make the hub's insufficient security testing that much more troubling. However, that is not our primary immediate concern. Last month's letter that was sent by the AGs and myself in 12 other States was prompted by the fact that HHS is not requiring groups receiving roughly $67 million in Navigator grants to properly screen, train, or conduct background checks on individuals who will be entering sensitive information into the Federal data hub.

The vice president of a Navigator group which received $1.2 million in grants for South Carolina said last week in The State paper, it is like Girl Scouts selling cookies, you go to the shopping centers and set up tables to capture people as they come and go.

The fact is it is more difficult to help Girl Scouts sell boxes of cookies than it is to become a health care Navigator. While groups like the Girl Scouts require employees to complete background checks, there are no such requirements for Navigators. This is despite the fact that HHS exchange regulations require Navigators to safeguard consumers' sensitive personal information, including, but not limited to, health, income, employment, tax, and social security information. The only requirement for Navigators is that they complete 20 hours of online training, less than most States require for a driver's license.

This weekend, newspapers across the Country ran headlines such as Rollout of Obamacare spawns slew of scams: Con artists are busy dialing seniors and other consumers as they try to cash in on the confusion around the Affordable Care Act. Last week, the Department of Insurance in our State issued a consumer alert due to the proliferation of online, in person, and telephone scams.

The first obligation of government is maintaining the safety and security of its citizens. Ironically, the implementation of a Federal program designed to provide health care to all Americans puts us all at severe risk because it is riddled with scams and security breaches. Americans should not have to barter their privacy and financial security for health insurance.

Thus far, the Administration's implementation of the Affordable Care Act undermines a fundamental responsibility of the Federal Government, the security of its citizens. Until HHS answers our questions and rectifies this matter by properly safeguarding American's personal information, Congress must suspend implementation of the ACA. Thank you.

[Prepared statement of Mr. Wilson follows:]

Prepared Remarks
South Carolina Attorney General Alan Wilson
House Oversight and Government Reform Committee
September 18, 2013

Thank you for the opportunity to share the concerns of Attorneys General from across the country. Last month, thirteen state Attorneys General, led by West Virginia's Patrick Morrissey, wrote Health and Human Services Secretary Kathleen Sebelius. Our letter outlined twenty-one simple, time-sensitive questions related to consumer protection and fraud prevention concerns associated with HHS Navigators and the implementation of the Affordable Care Act.[i]

My testimony today has nothing to do with the merits of the Affordable Care Act. It has everything to do with the first obligation of government, the security and safety of its citizens, and sharing with Congress the need to indefinitely suspend implementation of the Affordable Care Act until security risks are mitigated; privacy protections are provided; and legally mandated deadlines are properly met.

Despite the President saying last month "we're well on our way to fully implementing the Affordable Care Act," important deadlines are being routinely missed, and more importantly, security concerns are being dismissed. An unpublished Congressional Research Service memo cited by Forbes last month noted the Administration has missed more than half of the legally imposed implementation deadlines (41 of 73).[ii]

In order for the ACA to adequately determine the eligibility of consumers for exchange subsidies it must create a data hub that connects data bases from seven different agencies which include Medicare, Medicaid, the IRS, Homeland Security, HHS, VA and the Social Security Administration.

Last week, the Centers for Medicare and Medicaid Services confirmed the ACA's data "hub" complies with federal standards.[iii] However, the hub has not been beta-tested, independently verified or properly audited by the Inspector General. More troubling is the fact senior HHS technology officials lowered previous standards earlier this year by saying, "Let's just make sure it's not a third-world experience."[iv]

When it goes live on October 1, it may not be a third world experience, but it will be a con-man's all-you-can-eat buffet overflowing with a gold mine of sensitive information from Medicare/Medicaid, Social Security, IRS, Homeland Security, HHS, VA, and other government databases.

This information in the Hub should be guarded as if it were the gold in Fort Knox, not haphazardly. The Hub should be required to exceed minimally adequate protocols which have allowed the records of more than 20 million veterans to be compromised during at least eight hacks of the VA's unencrypted computer system between 2010 and 2013.[v]

States are also victim of similar attacks. Exactly one year ago, more than 3.6 million South Carolinians were put at risk when hackers obtained our social security numbers and personal information during a major security breach at the South Carolina Department of Revenue.[vi]

Such attacks make the Hub's insufficient security testing that much more troubling. However, that is not our primary immediate concern. Last month's letter was prompted by the fact that HHS is not requiring groups receiving roughly $67 million in Navigator grants to properly screen, train, or conduct background checks on individuals who will be entering sensitive information into the federal data hub.

The Vice President for a group which received a $1.2 million grant to "conduct target marketing campaigns and public education events" throughout South Carolina[vii] said last week (in The State), "It's like the Girl Scouts (selling cookies), you go to shopping centers and set up tables to capture people as they come and go."[viii]

The fact is - it is more difficult to help Girl Scouts sell boxes of cookies than it is to become a Healthcare Navigator.[ix] While groups like the Girl Scouts require employees to complete background checks, there are no such requirements for Navigators. This is despite the fact that HHS Exchange Regulations require Navigators to "safeguard consumers' sensitive personal information" including but not limited to health, income, employment, and tax, and social security information.[x] The only requirement for Navigators is that they complete 20 hours of online training, less than most states require for a driver's license.

This weekend, newspapers across the country ran headlines such as, "Rollout of Obamacare spawns slew of scams: Con artists are busy dialing seniors and other consumers as they try to cash in on the confusion around the Affordable Care Act."[xi] Last week, the South Carolina Department of Insurance issued a consumer alert due to the proliferation of online, in person, and telephone scams.[xii]

The first obligation of government is maintaining the safety and security of its citizens. Ironically, the implementation of a federal program, designed to provide health care to all Americans, puts us all at severe risk because it is riddled with scams and security breaches. Americans should not have to barter their privacy and financial security for health insurance.

Thus far, the Administration's implementation of the Affordable Care Act only does violence to the fundamental responsibility of the federal government, the security of its citizens. HHS must answer our questions and rectify this matter. If Americans' personal information cannot be safeguarded, the Administration must be held accountable.

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Mr. LANKFORD. Representative Jackson.

STATEMENT OF THE HONORABLE KATRINA R. JACKSON

Ms. JACKSON. Members of this committee, I serve in Louisiana as a State legislator as a member of the House Health and Welfare Committee, Joint Committee on Budget, and the Committee on Appropriations.

The United States Supreme Court has emphatically stated what the law is relative to health care in the United States of America. In upholding the Patient Protection and Affordable Care Act. However, we sit here today continuously debating this law, instead of working together to ensure that this implementation is beneficial to all States and all citizens of the United States.

In a State where almost 900,000, some 20 percent of Louisiana's population, is uninsured and the health care budget has been cut by 10 percent each year for five consecutive years, we cannot afford to decline any portion of the Affordable Health Care Act. Our governor advocated for us cutting one of the most vital health care services offered to any State's constituency, our hospice care, to take care of the problem, he said.

As a State representative who represents Louisiana citizens who have entrusted us with the duty to ensure that we do all we can to represent them, I cannot, in good conscience, in good moral conscience, advocate for the repeal or de-funding of the Affordable Health Care Act, for in doing so I would fail an overwhelming number of the constituency in my State.

The secretary of the Louisiana Department of Health and Hospitals, who sits next to me today, will neglect to mention that she, herself, and her Department published a report that reflects up to a $367.5 million savings while offering health care to over 400,000 of our uninsured citizens, almost half of those on the uninsured roll. Our independent, nonpartisan legislative fiscal office arrived at an even higher number in savings to Louisiana and its citizens, almost $550 million.

DHSH will stand before you today on behalf of Louisiana complaining about the difficulty in implementing this Act. However, they have wasted countless time supporting measures such as one that we voted down last session, in this current year, which would have required us to take a vote of referendum of our people by two-thirds vote in order to enact any portion of the Affordable Health Care Act.

Louisiana spends over $600 million in uncompensated care yearly, mainly through DISH dollars that we continuously request from the Federal Government. We are one of the top five States who receive and expend these dollars. Independent reports reflect that the Affordable Health Care Act will save the Federal Government approximately 50 percent of all DISH dollars spent around this Nation. That is the long-term savings. The immediate savings in 2014 show approximately $500 million in savings to this Federal Government.

Louisiana's economy, just like many other States, has suffered during these tough economic times. The full implementation of the Affordable Health Care Act offers an injection of $26.8 billion in our State's economy and will create over 47,000 jobs in the State

of Louisiana. It will further aid businesses by contributing greatly to a healthier, more productive workforce. The Federal insurance exchange is beneficial to those currently paying insurance premiums by creating a more competitive market and driving down the costs of insurance premiums for everyone.

Somewhere in Louisiana, and all across this Nation, there are younger versions of you and myself who aspire to matriculate in institutions of higher learning without having to worry about whether they will have insurance or not. The Affordable Health Care Act offers them access to the American dream, something that most of us have already been through. By allowing them to remain covered under their parents' premiums, their parents, who are mostly middle-to upper-class citizens, have paid for those premiums.

In each of our great States, just like Ms. Ritter, who sits here today, there are families with children or sick parents who have been diagnosed with life-threatening conditions and have been told that they have reached their mandatory maximum of benefits. I say to you today our good conscience tells us that we must respond to their needs, and the Affordable Health Care Act has done so. But if you don't believe me, a great writer once penned our great lord and savior Jesus Christ when he told us that what we do to the least of these we also do to him. It is time to do what is right.

Mr. LANKFORD. Secretary Kliebert.

STATEMENT OF KATHY KLIEBERT

Ms. KLIEBERT. Good morning. Thank you for the invitation to highlight how the implementation of the Patient Protection and Affordable Care Act has presented major problems for Louisiana. My name is Kathy Kliebert. I am the Secretary of the Department of Health and Hospitals in Louisiana. I have served the Department for over 25 years, primarily working with individuals who have behavioral health challenges and those individuals with developmental disabilities.

Since the Affordable Care Act was signed into law, we have repeatedly shared our concerns with the law itself and with its implementation. Over the past few years we have seen our fears become reality, and our decision to not establish a State-based exchange in Louisiana validated. As a complex project with often delayed and frequently changing guidance, it is not surprising that many States, and even the Federal Government, are narrowing the scope of their day one exchange capabilities as we near the mandated launch.

Though this law was passed over three years ago, much of the critical guidance and regulations have only been issued in this past year, and they continue to change. For example, CMS released in June what they claimed to be the final version of guidance that will govern interactions between the exchange and State Medicaid programs. However, we have since learned that new changes are forthcoming, which will likely require significant reprogramming efforts for our Medicaid eligibility system.

Critical questions often take three to four months for a response, wasting precious time and resources that easily could have been avoided and cannot be afforded as we near federally mandated deadlines.

We have also faced conflicting messages and confusing misinformation. In just one example, we recently experienced confusion about whether pregnancy was considered a qualifying life event for women to enroll in the exchanges outside of the designated open enrollment period. The Federal Government's own website recently changed the definition of a qualifying life event, removing the event of becoming pregnant and now stating that it is the birth of the baby that qualifies the woman for coverage.

After seeking clarification, we have received multiple and conflicting answers from HHS officials. The screen shots included in my written testimony, taken just a few weeks apart, illustrate this frustrating inconsistency.

We are also troubled with how HHS is conducting education and outreach in States with a Federal exchange, where they have assigned much of the responsibility to federally-funded Navigators. Named only weeks ago, these groups have had barely a month and a half to prepare. There is almost no oversight or standards for how they will work, and their training requirements have actually been scanned down by HHS.

We also have serious concerns about the call centers that will provide much of the direct consumer assistance. We learned from a press release that a call center will be operated in the small town of Bogalusa, Louisiana, but its operations are only starting this month, meaning their employees will have less than a month of training before launch.

Just last week we were alarmed to hear that a constitute who called the exchange hotline was told that many States are expanding their Medicaid eligibility. He was told to first call the State to see if he may now qualify for Medicaid, even though Louisiana has very publicly stated that it will not expand Medicaid eligibility. If the Federal call center employees are not equipped with such basic information, how are they expected to help individuals navigate this enormously complex program?

We have also been frustrated by numerous technical issues that have resulted in duplicate efforts for States, particularly as it relates to the single streamline application for both Medicaid and the exchange and the new Federal data services hub. For example, we asked CMS for the ability to link directly to the single streamline application being built at the Federal level, rather than duplicate those efforts at the State level. We were told that each State was responsible for building its own application based on the Federal version, which was not made available until April of this year. We then made multiple requests to CMS this summer for its online application source code in order for our contractor to verify Louisiana's version. It was never provided to us.

In March, Federal officials promised to provide States with a no-cost solution to meet the newly mandated, Modified Adjustor Gross Income standard for Medicaid eligibility. However, we learned in a June conference call that we had the responsibility. We anticipate that it will take our contractor more than 5,000 hours of work to meet all the related mandates, for a total cost of $750,000. To frustrate matters further, we learned last week the Federal solution was finally ready, far too late to be useful.

While I have only highlighted our major concerns, we expect more problems to arise, as October is just two weeks away. While these facts raise serious questions about whether implementation of the exchanges should be delayed, we continue to believe the best solution for our Nation and our State is that the entire law be repealed and replaced with a more affordable and market-driven solution that gives States the flexibility to design programs that best meet the needs of their individual populations. Thank you.

[Prepared statement of Ms. Kliebert follows:]

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana
Department of Health and Hospitals
Office of the Secretary

TESTIMONY

Hearing on

"Federal Implementation of Obamacare: Concerns of State Governments"

September 18, 2013

Statement of
Kathy H. Kliebert
Secretary
Louisiana Department of Health and Hospitals

Before the
Subcommittee on Energy Policy, Health Care & Entitlements
Committee on Oversight & Government Reform
U.S. House of Representatives

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Introduction

Good morning, Chairman Lankford, Ranking Member Speier, Chairman Jordan, Raking Member Cartwright, and distinguished members of the subcommittees. Thank you for the invitation to testify on the obstacles we are facing at the state level as the Patient Protection and Affordable Care Act (PPACA) is implemented, particularly as it relates to the Federally-Facilitated Health Insurance Exchange in Louisiana.

My name is Kathy Kliebert, and I am the Secretary of the Louisiana Department of Health and Hospitals (LDHH) and senior health policy advisor to Governor Bobby Jindal. Prior to my appointment as secretary, I served as the Department's deputy secretary, where I provided leadership to the agency's program offices, including the Offices for Citizens with Developmental Disabilities, Behavioral Health, Public Health, and Aging and Adult Services. Prior to my appointment as Deputy Secretary, I led the Office of Behavioral Health, where I managed the merger of the Department's mental health and addictive disorders offices to better serve Louisianians in need. I also spearheaded the development and implementation of Louisiana's new approach to both delivering and financing behavioral health services for approximately one million Louisiana children and adults through a fully integrated, single-point-of-entry system.

I have dedicated the bulk of my career to serving individuals with developmental disabilities through the Department's Office for Citizens with Developmental Disabilities (OCDD), which I also led as Assistant Secretary for six years. During my tenure with OCDD, we successfully completed a multi-year transition to move individuals out of institutions and into community-based services, reducing the number of individuals living in institutions by more than 26 percent. Prior to leading OCDD, I served as diversification director of the Metropolitan/Peltier-Lawless Development Centers in New Orleans and Thibodaux, where I led the expansion of community-based options for people with developmental disabilities. I have more than 20 years of experience as a licensed clinical social worker and have a master's degree in social work. I also currently serve as Secretary of the Louisiana Educational Television Board and as a member of the Louisiana Children's Cabinet.

Introduction

Since PPACA was signed into law, we have repeatedly shared our concerns regarding its policy implications, lack of sufficient guidance and unreasonable timelines for implementation. Over the past few years we have seen our warnings become reality. Today, I would like to address some of those continuing concerns.

On March 23, 2011, the State of Louisiana announced that it would not assume the risk of building a state-based health insurance Exchange as outlined by the PPACA. Over time, this has proven to be a sound decision for our state and for the 33 others who joined us. Just last week, a senior official from one of the leading consulting groups assisting states with Exchange development, Leavitt Group, told your colleagues on the Health Subcommittee of House Energy and Commerce that not a single state-operated Exchange appeared to be completely ready to launch on October 1, 2013. As was noted in his testimony, these Exchanges remain an enormously complex IT project with frequently changing and delayed guidance. It is not surprising that many states are narrowing the scope of their day-one Exchange capabilities as we near their mandated launch.

Meanwhile, contractors building the federal Exchange that will serve 34 states have, under the close watch of the U.S. Department of Health and Human Services (HHS), unsurprisingly offered their assurances that the federal Exchange will launch on October 1. Despite these reassurances, I am frustrated by what appears to be, based on our own front-line experience, a lack of forthrightness from federal officials and contractors about the status of critical components. With less than two weeks until the doors open for individuals to enroll, many questions remain about whether the systems are ready.

There is a common misconception that states that have opted not to expand their Medicaid programs or build their own Exchange are free of the onerous mandates of PPACA. To the contrary, we are faced with numerous new requirements, which I will highlight. Through my testimony I will describe the major hurdles Louisiana has faced, touching on the three main areas of concern, which are (1) guidance from CMS, (2) conflicting messages and misinformation, and (3) technical issues and delays.

Exchange Implementation Issues

Although PPACA was signed into law in 2010, it was not until this past year that federal officials began to release the bulk of the guidance related to critical components of this law. While we have elected not to expand Medicaid or establish our own Exchange, our staff, particularly our Medicaid eligibility and information technology teams, has been working non-stop to meet the complex new mandates set by the law. Although our concerns are many, the main issues we have experienced thus far with the rushed implementation of this law are described as follows.

Guidance

Much of the guidance and regulations have been issued in rapid succession over the past year. This condensed timeline has provided states with far too little time to carefully read and thoroughly understand them, much less provide meaningful questions and comments. Even more concerning is that the rules keep changing. For example, CMS released in June 2013 what it claimed to be the final version of guidance that will govern how interactions between the Exchange and state Medicaid programs will work, but we have since learned from CMS officials that they are making tweaks to this without a firm delivery date. While we are unsure what these changes will include, we know they will likely require reprogramming efforts for states.

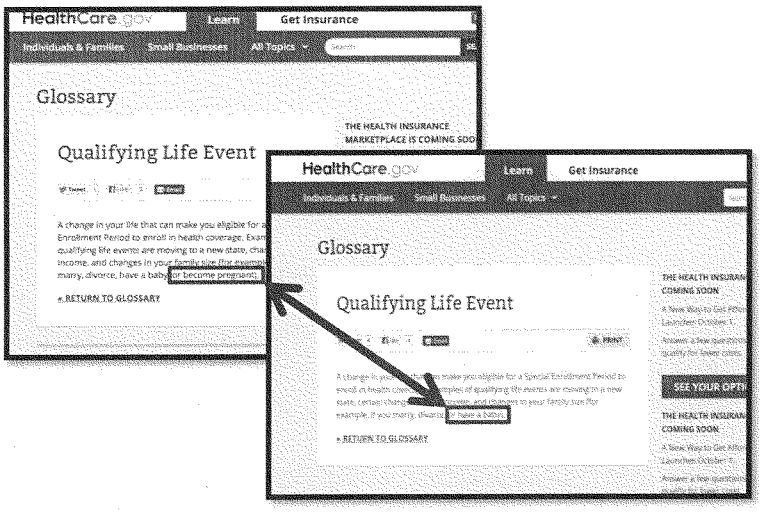
In addition to the issues we face because of late guidance releases, we've struggled to get timely answers to pertinent questions from federal officials. For example, on April 1, 2013, CMS agreed to provide details on how data transfers would be structured in response to requests made by Louisiana Medicaid staff on multiple occasions. This information was never received and our contractor was forced to comply by other means, wasting precious time and resources, which could easily have been avoided with proper guidance. It would often take CMS three or four months to respond to other critical questions about eligibility operations. We cannot afford to wait months for these answers as we prepare for the fast approaching, federally-mandated readiness deadlines.

Conflicting Messages and Misinformation

While there are clearly many dedicated career officials at the federal level working on PPACA, they've been tasked with the job of implementing an unworkable law within an

even more unrealistic timeframe. As a result, it is not surprising that states are often faced with conflicting and changing guidance.

To provide just one example, Louisiana Medicaid eligibility staff recently requested clarification on the issue of whether pregnancy is considered a "qualifying life event" to enroll in the Exchanges outside of the designated open enrollment period. Until very recently, HHS's primary Exchange Website, Healthcare.gov, had included in its definition of qualifying life event the example of when you "become pregnant." However the information on the site recently changed to state that it is the birth of the baby that qualifies the woman for coverage. On our requests for clarification, we've received multiple and conflicting answers from various HHS officials. The below screenshots, taken only a few weeks apart, illustrate this frustrating inconsistency.



Healthcare.Gov - Glossary

Additionally, we continue to be concerned with how HHS is conducting education and outreach in states. Although HHS set aside $1 billion for the implementation of PPACA, the agency has made repeated requests for billions more, including solicitations to private industry.[1] Though HealthCare.gov is the main Website for consumer information and is the access point for the federal Exchange, it was only redesigned and focused for consumer access at the end June 2013, on the same day its corresponding call center launched a soft

[1] Budget request denied, Sebelius turns to health executives to finance Obamacare, Washington Post, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/10/budget-request-denied-sebelius-turns-to-health-executives-to-finance-obamacare/, May 10, 2013.

open.[2] Most concerning is the fact that federal officials have assigned much of their responsibility for education and outreach in Louisiana to federally-funded "Navigators," which were only announced on August 15, 2013. With almost no oversight, these groups have essentially a month in a half to train their staff on the complex workings of this new federal program and to begin educating the public about how to appropriately access the Exchange and make an informed decision.

Furthermore, we have serious concerns with how effective the Exchange call center will be in answering consumer questions. Similar to the Navigators, the call centers that were contracted to answer consumer questions and enroll individuals are on a rapid timeline for hiring and training. In July 2013, it was announced that a 600-person call center serving seven states with a federal Exchange was being opened in the small town of Bogalusa, Louisiana with an anticipated start to operations expected in September 2013.[3] That means the employees in the call center answering consumer questions will have less than a month of training. We were alarmed this past week upon receiving word from a constituent in Louisiana who had called the Exchange hotline to find out about how he could enroll in a health plan on October 1, only to be directed to first contact his state's Medicaid office. He was told that many states are expanding their Medicaid eligibility and he may now qualify for the Medicaid program in Louisiana. This left the individual in a frustrating cycle as our staff had to answer basic questions about the Exchange and direct him back to the appropriate channels. If the federal call center employees do not even know basic information like which states are expanding Medicaid and which are not, how are they to be expected to help individuals navigate the complex process of qualifying for an advanced premium tax credit and selecting from potentially hundreds of health plan coverage options?

Technical Issues and Delays

We've already seen delays of critical pieces of the law, including the mandate that larger employers offer health coverage to their workers and the requirement for state-based Exchanges to verify applicant income. Other delays have forced compromises in readiness. I previously mentioned how the organizations tasked with helping people enroll are only now starting to be trained. Some of those training requirements, such as those for the navigators, now have been scaled back from a requirement of 30 hours of training to only 20.[4]

We're additionally concerned about the lack of interoperability between systems and a duplication of efforts. PPACA was touted as a means to sync state and federal operations, notably through efforts such as the single streamlined application and the federal data services hub. Both efforts have proven to be problematic.

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[2] HHS launches Health Insurance Exchange educational tools, http://www.hhs.gov/news/press/2013pres/06/20130624a.html, June 24, 2013.
[3] General Dynamics brings 600 new jobs to Bogalusa, http://www.fox8live.com/story/22970885/general-dynamics-brings-600-new-jobs-to-bogalusa, August 6.
[4] Preparations for Health Exchanges on Tight Schedule, http://online.wsj.com/article/SB10001424127887324170004578638100820728288.html, August 7, 2013.

For example, Louisiana requested an ability to link to the single streamlined application being built on the federal level as replicating those efforts at the state level would be a costly duplication. It was then our understanding that each state was responsible for building its own single, streamlined application, based on the federal version (which was not completed until April 2013). Essentially, each state would be duplicating efforts already made by the federal government. Multiple requests were made to CMS in July of this year for its online application source code, in order for our contractor to check the coding being used for Louisiana's version. That source code was never provided to us.

One of the criticisms most frequently cited recently has been the delay in and lack of security and functionality testing for components of the Exchange. As you are surely aware, the Government Accountability Office (GAO) warned in June 2013 of a likely delay in its launch, and just last month the HHS Office of the Inspector General pointed out that testing of the new "data services hub" that will support the Exchange was more than a month behind schedule. The final deadline for certifying the security of the system was pushed back to Sept. 30 – one day before the Exchanges are set to go live. Given the highly sensitive nature of the information that will be transmitted through this process, this is most concerning.

The problems are not just isolated to the inner workings, but could have a real impact on consumers. It was revealed on a recent conference call between federal contractors and insurance industry representatives that there were significant issues with how information about health plan cost information was being displayed on the new Exchange website[5]. One Florida insurer noted that their information made it appear that there was no charge at all for some medical services, when in fact that was only the case after a deductible had been met. This led to federal officials delaying their timeframe for signing final agreements with companies issuing health plans on the federal Exchange while these issues were worked out.

New federal requirements have also placed a significant burden on states. For example, states are required to convert their Medicaid eligibility standards to the new MAGI (Modified Adjusted Gross Income) standard. This requires extensive modifications to states' Eligibility systems and external interfaces. In a March 2013 CMS presentation, Federal officials promised to provide states with a no-cost solution called "MAGI-in-a-box." State integration and testing for this solution was initially scheduled for the end of May 2013. However, Louisiana Medicaid staff learned on June 13, 2013, during one of our regularly scheduled calls with CMS, that the service would not be available after all. We were told that we should now consider other alternatives. This left the state with the responsibility of executing contracts and conducting systems modifications to meet the October 1, 2013 deadline. We anticipate it will take our contractor 5,437 hours of work at $138.86 per hour to meet all of the MAGI-related mandates, for a total cost of roughly $750,000. To frustrate matters further, we finally learned last week that the federal solution was ready – far too late to be useful as we've already had to complete the work in order to meet CMS deadlines.

While states are faced with onerous and often unalterable federal deadlines, we've learned that HHS officials often apply a different standard to themselves. Just this last week,

[5] Technical snafus confuse charges for Obamacare plans, http://www.reuters.com/article/2013/09/05/us-usa-healthcare-technology-idUSBRE98405E20130905, Sep. 5, 2013

Louisiana Medicaid staff attended the MESC Conference in Charleston and learned from a Deputy Director for the Centers for Medicaid and CHIP that the federal government would not be ready to make account transfers on October 1, 2013, as it was supposed to do. The federal Exchange is intended to have the capability of making Medicaid eligibility determinations using our eligibility guidelines and transferring the applicant's file to the state to activate coverage. With that capability now delayed, we asked what CMS's contingency plan was, and the official stated the Exchange was going to hold the application and tell the individual that if they needed immediate coverage they should contact the state directly, which essentially requires individuals to apply twice. The CMS official could not provide a timeframe for how long it would take the agency to have the system ready to make transfers. It is extremely frustrating that states are often told that our compliance by hard deadlines is expected while federal officials delay their own capabilities and requirements repeatedly.

Conclusion

I'd like to reiterate that although Louisiana is not operating our own Exchange or expanding our Medicaid program, we are not free of the impact of this law, nor are our residents. In my testimony I described some of the major hurdles Louisiana has faced as federal officials force a rushed implementation of this law, though I did not touch on every issue that we have faced. Certainly, we expect more problems to arise as October 1, 2013 approaches. Without timely, clear guidance from CMS, and facing an abundance of conflicting messages, misinformation, and numerous technical issues and delays, Louisiana continues to have serious concerns about the implementation of the Affordable Care Act. While these facts raise serious questions about whether implementation of the Exchanges should be delayed, we continue to believe that the best solution for our nation and state is that the law be repealed and replaced with a more affordable and market-driven solution that gives states the flexibility to design programs that best meet the needs of their individual populations.

Mr. LANKFORD. Senator Sobel.

STATEMENT OF THE HONORABLE ELEANOR SOBEL

Ms. SOBEL. Good morning, Chairman Lankford, Chairman Jordan, Ranking Member Speier, Ranking Member Cartwright, and members of the committee. Thank you for extending me an invitation to testify today on the Federal Implementation of Obamacare. Concerns of State Governments. I am excited and eager to elucidate the problems we have encountered and address opposition to the implementation of the Affordable Care Act in Florida.

My name is Eleanor Sobel, and I represent the 33rd District in the Florida Senate. I was first elected to the Florida Senate in 2008 and I serve as chairwoman of the Florida Senate Children, Families, and Elder Affairs Committee. I also serve as vice chair of the Florida Senate Ethics and Elections Committee, as well as vice chair of the Florida Senate Health Policy Committee, vice chair on the Senate Select Committee for Affordable Health Care, as well as a delegate to the National Conference of State Legislators in an overwhelmingly predominant Republican Senate.

I wish I could be here with better news, telling you that the State legislature managed to put partisan politics aside and expand coverage to millions of uninsured individuals. Unfortunately, as you may know, this is not the case. Regular session, our spring session, concluded with the legislature being unable to pass on a bill to expand coverage.

I am here to also tell you that the State of Florida is actually punishing its people by putting up roadblocks and barricades to obtaining quality, affordable, accessible health care. The message some of Florida's Republican leaders are sending, would you believe, sound something like this: Health care is a privilege, not a right, and don't expect help from the government. Another message that is going forth was: We are here to put up barricades and obstacles, and to create public chaos and misinformation all in the name of political warfare.

The Florida House, Senate, governor, and cabinet are divided, split. The Senate wishes to move forward with Obamacare. We came up with a bipartisan bill in the Florida Senate that was a public-private partnership that actually would cover 1.5 million people in Florida, as well as use the $52 billion of the money from the Federal Government to help implement the program. Our Senate President Gates has also made overtures to work with Secretary Kathleen Sebelius. However, the House, governor, and cabinet are irrationally and ideologically preventing the execution and implementation of a policy that the citizens of Florida so desperately require.

Florida has the second highest percentage of uninsured residents in the Nation, at 25.3 percent. Florida has rejected again the $5.2 billion over a 10-year period of Federal Medicaid money, which would have served 1.5 million Floridians. The Florida House will not go along with the Senate's public-private expansion plans, and Governor Rick Scott often contradicts himself, saying he support Medicaid expansion and then does an about-face by trying to defeat implementation of Obamacare.

I want to focus on the two most important Florida sandbag issues that I have encountered in the implementation of affordable health care in Florida.

Sandbag number one: What is the best way to defeat a program? Answer: Make sure no one knows about it or understands how it affects the well-being of its citizens.

Just recently, Governor Scott has implemented a policy that would prevent the 60 Departments of Health from carrying out much needed education to the uninsured, claiming that health care education, known as Navigators, will be allegedly violating HIPAA laws. This is a desperate attempt to prevent access to those who need health insurance the most.

Sandbag number two: Last session, the Florida legislature passed a bill that handcuffed the insurance commissioner to use his State authority to negotiate lower rates of premiums for two years. Affordable insurance is a key part of Obamacare. Although Florida has agreed to a federally-run marketplace, the Federal Government can only rule if rates are reasonable or unreasonable, but cannot negotiate lower rates. We needed the insurance commission to provide the lowest rates possible so people would sign up. Hopefully, tax credits will reduce costs and make insurance affordable.

We must find a way to put aside Florida's differences and move forward with the Affordable Care Act. We must move forward with this very, very important Act and rectify Florida's political stalemate. Thank you very much for your consideration.

Mr. LANKFORD. Representative Hudson.

STATEMENT OF THE HONORABLE MATTHEW HUDSON

Mr. HUDSON. Good morning, Chairman Lankford, Chairman Jordan, and members of the committee. Thank you for inviting me to speak with you today. My name is Matt Hudson, and I am honored to represent District 80 in the Florida House of Representatives. I also chair the Florida House Health Appropriations Subcommittee, serve as vice chair of the Florida House Select Committee on PPACA, and cochair of the National Conference of State Legislatures Health Committee. I am also a Florida realtor.

Remember when you bought your first home? You saved money, found a home you liked. And then what if your realtor had handed you a contract and you had to review it and three of the pages were blank, and then when you questioned it they said trust me? I am positive none of you would have invested your money that way. I am positive that the citizens of Florida expect their government to make well-informed decisions, not based on Federal promises like trust me. But that is exactly what the ACA has forced us to do.

What we do know doesn't look very good. The ACA will make our health workforce shortage even worse and has led to skyrocketing premiums. It has kept States uninformed and puts consumers' privacy at risk through the insurance exchanges. And its Medicaid expansions threaten patients' health and taxpayers' bottom line.

The ACA will make our health workforce shortage even worse. By 2020, we will have a national shortage of more than 90,000 physicians and 1.2 million nurses. In Florida, about 13 percent of our physician workforce is retiring in the next five years, and we are

currently already short 753 doctors in our 248 primary care crisis areas. A massive influx of Government-subsidized health care recipients, because of the ACA's insurance exchanges and Medicaid expansions will make things much worse. Because of the ACA, patients will face even longer wait times and worse access to specialty care. Costs will obviously spike as the demand for limited health care services will dramatically increase.

The ACA will drive patients' premiums higher. We were promised the ACA would let us keep the plan we like and the doctors we trust, but the premium increases resulting from the web of new regulations and mandates make that an empty promise for millions of Floridians. The Florida Office of Insurance Regulation projects that our small group and individual market premiums will rise an average of between 5 and 40 percent. Will these folks have to choose between prohibitively high premiums and fear of Government-run health care or no coverage at all? Where is the promise in that?

Washington isn't providing answers about insurance exchanges or protecting citizens' privacy. As Florida weighed whether the State or the Federal Government would build a State-based exchange, we had questions that needed answering. These questions were included in a three-page November 2012 letter from our House speaker and our Senator president to HHS. They did not respond until January, after our exchange decision deadline. And the response was just three brief paragraphs that did not answer any of our questions.

Based on the final HHS rules for federally-facilitated exchanges, Florida made the right decision in rejecting a State-based exchange. Still, the time line and HHS's non-cooperation made an informed decision process impossible.

What we did know is that the exchange applicants will have to hand over social security numbers, birth dates, employment information, tax returns, and much more, all the information needed for identity theft, and we took action. Florida passed a law that required the registration of exchange Navigators, which included background screenings, disqualifications for certain crimes, and penalties for improper actions.

Medicaid expansion is wrong for patients and taxpayers. Medicaid is already a problem across the Nation; access is limited and outcomes are poor. The only randomized control trial of Medicaid ever conducted found no improvements in health when compared to the uninsured. Still, the Federal Government continues to push Medicaid expansion in Florida.

We rejected a Medicaid expansion to add another million people to the Medicaid rolls because we knew access problems would get much worse. And it has been difficult to estimate true costs of expansion. In Florida, official cost estimates for Medicaid expansion range from less than $30 billion over a 10-year period to nearly $55 billion.

And then as we learn more about expansion, cost estimates for Florida portion went from $1.4 billion to $3.5 billion. And even these estimates assume that the Federal Government will be able to keep its funding promises, despite carrying $17 trillion in debt.

States deserve answers to these questions. Washington is notorious for passing laws and leaving States to figure out how to make them work. In the case of ACA, we deserve to have our concerns heard.

Thank you, members of the committee, for giving me the opportunity to talk to you today, and I look forward to your questions.

[Prepared statement of Mr. Hudson follows:]

Prepared Statement of
Matt Hudson
District 80
Florida House of Representatives

before the

Subcommittee on Energy Policy, Health Care and Entitlements and the
Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs

Committee on Oversight and Government Reform
U.S. House of Representatives

September 18, 2013

Introduction

Chairman Lankford, Chairman Jordan, Ranking Member Speier, Ranking Member Cartwright, and members of the Committee, thank you for the invitation to testify on "Federal Implementation of Obamacare: Concerns of State Governments." I welcome this opportunity to share with you the challenges Florida has experienced in dealing with the Patient Protection and Affordable Care Act (PPACA).

My name is Matt Hudson and I represent the 80th District in the Florida House of Representatives. I was elected to office in 2007 and I serve as chairman of the Florida House Health Appropriations Subcommittee and vice-chairman of the Florida House Select Committee on PPACA. I also serve as co-chairman of the National Conference of State Legislatures (NCSL) Health Committee and as a member of the NCSL Health Reform Task Force.

State officials across the country have a vested interest in ensuring access to quality, affordable, private health insurance coverage for their citizens. My colleagues in the state of Florida are no different. Currently, 19 percent of Florida's population is uninsured.[1] Between 2008 and 2012, average private-sector employer-based premiums rose by 22 percent, or a compounded average increase of 5.1 percent per year.[2] We have 3.3 million Floridians in our Medicaid program, yet 41 percent of Florida's doctors won't accept new Medicaid patients.[3-4]

These problems existed before PPACA, and we look forward to working with our federal partners to make health coverage more affordable and accessible to all Floridians. Unfortunately, PPACA only makes these problems worse. Today, I'd like to discuss four areas of concern: one, Florida's health workforce shortages; two, the excessive premium increases on Florida's families; three, the haphazard implementation and privacy concerns surrounding health insurance exchanges; and four, PPACA's Medicaid expansion.

PPACA Makes Florida's Health Workforce Shortages Worse

The growth and aging of the U.S. population has increased demand for healthcare services.[5] The implementation of PPACA will substantially add to the demand for healthcare services,

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[1] U.S. Census Bureau, Current Population Survey, U.S. Census Bureau, http://www.census.gov/cps/.

[2] Based on 2008 Medical Expenditure Panel Survey-Insurance Component: Table X.D, U.S. Department of Health and Human Services (2009), http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_10/2008/txd.pdf and Agency for Healthcare Research and Quality, 2012 Medical Expenditure Panel Survey-Insurance Component: Table X.D, U.S. Department of Health and Human Services (2013), http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_10/2012/txd.pdf.

[3] Florida Agency for Health Care Administration, Florida Medicaid Managed Care [1915(b)] and Medicaid Pilot* (1115) Enrollment Reports As of September 1st, 2013, Florida Agency for Health Care Administration (2013), http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/RF_NR_SMMC/ENR_Sep2013.xls.

[4] Sandra L. Decker, In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help, Health Affairs (2012), http://content.healthaffairs.org/content/31/8/1673.

[5] Maria Schiff, The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care, National Governors Association (2012), http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf and A. N.

especially primary care services.[5] Currently there is an inadequate supply of healthcare practitioners in the U.S. to meet this growing need for healthcare services.

According to the Association of American Medical Colleges, the U.S. faces a shortage of more than 90,000 physicians by 2020 and the shortage will grow to more than 130,000 physicians by 2025.[7] According to the U.S. Bureau of Labor Statistics, the registered nurse workforce is the top occupation in terms of job growth through 2020. The number of employed nurses is expected to grow from approximately 2.74 million in 2010 to 3.45 million in 2020—an increase of 712,000, or 26 percent. Additionally there is a projected need for 495,500 replacements in the nursing workforce, bringing the total number of nursing job openings due to growth and replacements to 1.2 million by 2020.[8]

Florida's demographics, particularly its disproportionately large elder population, mean Florida will experience a greater healthcare workforce shortage than many other states. Florida's aging population currently includes many practicing physicians. Within the next five years, 5,810 (12.97 percent) of Florida's 44,804 active physicians plan to retire, adding to the workforce shortage dilemma.[9] Florida currently has a shortage of primary care physicians and would need 753 doctors just to eliminate the state's 248 primary care crisis areas.[10] The implementation of subsidized health insurance through the exchange, plus a PPACA Medicaid expansion, would generate the need for an additional 50,300 registered nurses to meet the demand for healthcare services in Florida.[11]

These shortages will affect access to health care negatively, both with regard to patient caseloads and price. Practitioners will have larger caseloads. Patients will have to wait longer for care and may have difficulty accessing the care they need. Increased demand for fewer resources leads to higher costs.

States can address healthcare workforce shortages by increasing the matriculation of practitioners in the state, competing for existing workforce resources by encouraging and

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Hofer, J. M. Abraham, and I. Moscovice, Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization, The Milbank Quarterly (2011), http://www.ncbi.nlm.nih.gov/pubmed/21418313.

[6] Id.

[7] Association of American Medical Colleges, Fixing the Doctor Shortage, Association of American Medical Colleges (2013), https://www.aamc.org/advocacy/campaigns_and_coalitions/fixdocshortage/.

[8] U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections – 2010-20, U.S. Department of Labor, Bureau of Labor Statistics (2012), http://www.bls.gov/news.release/pdf/ecopro.pdf. See also: Robert J. Rossiter, Nursing Shortage Fact Sheet, American Association of Colleges of Nursing (2012), http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf.

[9] Florida Department of Health, Physician Workforce Annual Report 2012, Florida Department of Health (2012), http://www.doh.state.fl.us/Workforce/Workforce/Annual_Reports/PhysicianWorkforceAnnualReport2012.pdf.

[10] Florida Department of Health, Presentation by State Surgeon General & Secretary of Health John H. Armstrong, M.D., before the House Select Committee on Patient Protection and Affordable Care Act, February 18, 2013, on file with Florida House Select Committee on PPACA staff.

[11] Florida Center for Nursing, RN and LPN Supply and Demand Forecasts, 2010-2025: Florida's Projected Nursing Shortage in View of the Recession and Healthcare Reform, Florida Center for Nursing (2010), http://www.doh.state.fl.us/Workforce/Workforce/Annual_Reports/PhysicianWorkforceAnnualReport2012.pdf.

removing barriers to migration from other states, and using existing in-state resources as efficiently as possible. Some of the methods to accomplish these goals include dedicating more funds to practitioner education programs, removing regulatory barriers to licensure, creating or expanding licensure reciprocity between states, and expanding scope of practice to ensure all practitioners practice to the greatest extent of their education, training, and experience.

Healthcare workforce regulation is traditionally the purview of state governments, not the federal government. The federal government's attempts to both increase access to care and reduce costs through PPACA will be thwarted by the failure to address workforce problems.

In Florida, the political and policy dialogue surrounding PPACA led us to consider significant changes to the way we produce and utilize health care practitioners as a way to mitigate the existing and looming health care workforce shortages. To that end, the Speaker of the House of Representatives, Will Weatherford, has convened a Select Committee to explore these issues and identify short-term and long-term solutions. We hope to improve Florida's regulatory position compared to other states, invest more wisely in education, and make it easier for health plans and health provider organizations to build networks and recruit practitioners. We want to make sure that Florida is in the best possible position to ensure our citizens have access to the best possible health care workforce.

PPACA Levies Excessive Premium Increases on Florida's Families

PPACA inflicts problems on both the supply and the demand side of health care. We must have a robust and innovative healthcare workforce to meet the health needs of all Floridians. But we also need to make health insurance more affordable so that Floridians can access that care. Contrary to its name, PPACA fails to make health care more affordable and will price increasing numbers of Floridians out of the healthcare marketplace.

Under the new federal health law, individuals are seeing their premiums skyrocket in Florida. There are a number of reasons for this. The law's guaranteed issue requirements, community rating provisions, minimum mandated benefits, age rating restrictions, actuarial value requirements, and new taxes and fees will all drive up the cost of health insurance.[12]

These provisions require insurance companies to accept all applicants, even if they wait until they get sick before applying for coverage, and the insurance companies are now prohibited from charging premiums based upon likely costs. So many individuals in the market today are seeing their premiums go up in order to subsidize others. These provisions also make individuals buy more robust coverage than they currently have, want, or even need. And the new taxes and fees on private insurance are simply being passed along to consumers.

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[12] House of Representatives Select Committee on PPACA, Committee Meeting Notice: January 25, Florida House of Representatives (2013), http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2738&Session=2013&DocumentType=Meeting%20Packets&FileName=PPACA%201-25-13%20ONLINE.pdf.

The Florida Office of Insurance Regulation (OIR) reports that premiums in our small-group market will rise by an average of 5 to 20 percent.[13] In our individual market, the results are even worse. According to OIR, premiums in our individual market are expected to increase by an average of 30 to 40 percent.[14]

Of course, insurance regulation has historically been a state power. As vice-chairman of the Florida House Select Committee on PPACA, I learned that PPACA had taken much of this state role and given it to the federal government without creating the regulatory structure to administer it. We learned that the U.S. Department of Health and Human Services (HHS) planned to leverage state infrastructure and resources to implement the PPACA insurance provisions—particularly state insurance regulatory departments.[15]

When we started the Select Committee meetings in January of 2013, the rules on insurance rating were not finalized. The insurance industry was facing a deadline of May 1, 2013 to submit products to HHS for approval to be sold on the exchange.[16] The rating rules did become final on February 27, 2013.[17] We knew that because of the lateness of the rule we would not know the full impact of PPACA on rates until after the legislative session ended.

Florida has a long history of transparency including extensive public records and open meetings laws—and the Select Committee realized that insurance rates were changing as a result of the actions of the federal government. We wanted Floridians to know and understand the effects of PPACA on their insurance rates. Since the federal government had superseded the role of the state in setting policy affecting insurance rates, we wanted to make sure the public understood that state could do nothing to affect rates.

As a result, the legislature passed Senate Bill 1842, which in part requires insurance companies to provide a one-time notice to policyholders that describes or illustrates the estimated impact of PPACA on monthly premiums.[18] The notice must also be submitted to OIR, which will post a summary of the notices on its website.[19]

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[13] Wences Troncoso, Patient Protection & Affordable Care Act (PPACA) Overview: Post-Legislative Session Update, Florida Office of Insurance Regulation (2013), http://www.floir.com/sitedocuments/PPACAUpdate07302013.pdf.
[14] Id.
[15] Florida House of Representatives, Select Committee on PPACA, Overview of the Patient Protection and Affordable Care Act, January 14, 2013, on file with Florida House Select Committee on PPACA staff.
[16] Wences Trocoso, Patient Protection & Affordable Care Act (PPACA) Overview, Florida Office of Insurance Regulation (2013), http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2738&Session=2013&DocumentType=Meeting Packets&FileName=PPACA1-25-13 ONLINE.pdf.
[17] U.S. Department of Health and Human Services, Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, Federal Register 78 FR 13405 (2013), https://www.federalregister.gov/articles/2013/02/27/2013-04335/patient-protection-and-affordable-care-act-health-insurance-market-rules-rate-review.
[18] Senate Appropriations Committee and Senate Banking and Insurance Committee, CS/SB 1842, Florida Senate (2013), http://www.flsenate.gov/Session/Bill/2013/1842/BillText/er/PDF.
[19] Id.

The information in the notice must be based on the statewide average premium for the bronze, silver, gold, or platinum level plan, whichever is applicable to the policy, and provide an estimate of specified effects of the following PPACA requirements:[20]

- The dollar amount of the premium attributable to the impact of guaranteed issuance of coverage;
- The dollar amount of the premium attributable to fees, taxes, and assessments;
- For individual policies, the dollar amount of the premium increase or decrease attributable to the combined impact of the age and gender rating requirements of PPACA, shown for specified age brackets for males and females; and
- The dollar amount attributable to the requirement to cover essential health benefits and to meet a required actuarial value, as compared to the statewide average premium for the policy that has the highest enrollment in the individual or small group market, whichever is applicable.

OIR developed the form this summer with input from industry and advocacy groups. In Florida, our citizens will know the true costs of PPACA and will be able to judge for themselves if the costs are worth the value they receive from their new insurance policies.

Haphazard Implementation of PPACA Exchanges Threatens Both Policymaking and Privacy

The Florida Select Committees on PPACA spent a great deal of time learning about our policy options under PPACA, including our choices for the structure and operation of Florida's health insurance exchange. In several areas of PPACA, the federal government made assumptions about the degree of state willingness to participate in implementation. For the members of Florida's Legislature, the decision concerning what kind of exchange would operate in Florida turned on whether there were any meaningful policy choices we could make in a state-based exchange or partnership to tailor the exchange to meet Floridians' unique needs.

We needed information on how the federal government would run the federally-facilitated exchanges (FFEs) in order to evaluate and decide whether Florida would benefit from taking on this role of building and operating an exchange. What policy choices would HHS make? For example:

- Would the FFE be an active purchaser, or an open market?
- Would Florida be one statewide rating area, or divided into many rating areas? If the latter, how many areas and what would they look like?

[20] Florida Office of Insurance Regulation, Notice of Premium Impact Template, Florida Office of Insurance Regulation (2013), http://www.floir.com/siteDocuments/NoticeofPremiumImpactsTemplate.xlsx.

- Will the FFE have an outreach program, and what will it look like?
- What is the process for transitioning from a FFE to a state-based exchange?
- What are the procedural and technical requirements for connecting to the federal data hub?

However, federal timelines and a lack of information made the legislative process difficult. The federal deadline for a state to notify HHS that it planned to have a state-based exchange was originally November 16, 2012, and was extended to December 14, 2012.[21] The notice deadline for a partnership exchange election was February 15, 2013.[22]

We were being forced to make this important decision before the federal government had addressed these and many other questions in either rules or guidance. Prior to the deadlines for declaring which exchange model Florida would pursue, the Speaker of the House of Representatives and the Senate President submitted a joint letter to HHS detailing a list of questions they believed needed to be answered in order for the Florida Legislature to make an informed decision.[23] They received a response in January—after the notice deadline for a state-based exchange—which contained no answers to any of the questions.[24]

In an attempt to get answers to some of our questions, the legislature invited Center for Consumer Information and Insurance Oversight (CCIIO) staff to attend a committee meeting and discuss exchanges with the members of the Select Committees.[25] Over a period of weeks of communication, Select Committee staff first was advised that CCIIO does not have a travel budget so no one from CCIIO could attend in person.[26] Later they were told CCIIO officials are not allowed to meet officially with state legislatures; rather, they are permitted only talk informally and not in public.[27] This created understandable problems given our open

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[21] Kathleen Sebelius, Letter to The Honorable Bob McDonnell and The Honorable Bobby Jindal, U.S. Department of Health and Human Services (2012), accessed at http://healthreformgpsdev.forumone.com/resources/sebelius-grant-rga-request-for-more-time-to-decide-on-a-state-run-exchange/.

[22] Id.

[23] Don Gaetz and Will Weatherford, Letter to The Honorable Kathleen Sebelius, Florida Legislature, November 15, 2012, on file with Florida House Select Committee on PPACA staff.

[24] Gary Cohen, Letter to The Honorable Don Gaetz and The Honorable Will Weatherford, U.S. Department of Health and Human Services, January 14, 2013, on file with Florida House Select Committee on PPACA staff.

[25] E-mail from staff of the U.S. Department of Health and Human Services to staff of the Florida House of Representatives Select Committee on PPACA, December 17, 2012, on file with Florida House Select Committee on PPACA staff.

[26] E-mail from staff of the U.S. Department of Health and Human Services to staff of the Florida House of Representatives Select Committee on PPACA, January 2, 2013, on file with Florida House Select Committee on PPACA staff.

[27] E-mails from staff of the U.S. Department of Health and Human Services to staff of the Florida House of Representatives Select Committee on PPACA, January 28, 2013, January 29, 2013, and January 30, 2013, on file with Florida House Select Committee on PPACA staff.

government laws, so we were not able to schedule the meeting. The February partnership deadline passed without any answers.

The final rule for the FFEs came out in late March of this year, in the middle of Florida's legislative session and long after the deadlines for deciding on FFE alternatives. While the substance of the rules happened to affirm Florida's policy decision to have a federally-facilitated exchange, the federal timeline made a more thoughtful, informed decision process impossible, further damaging a federal-state relationship already stressed by PPACA's assumptions about states' willingness to participate.

The federal government's haphazard implementation of exchanges affected Florida's ability to craft sound public policy. And now our most vulnerable Floridians will be impacted, thanks to the exchange navigator program that lacks meaningful privacy protections.

These exchanges—and the people helping run the exchanges—will be handling all kinds of personal information of consumers. Consumers will be handing over Social Security numbers, dates of birth, addresses, employment information, tax return information, and much more, not just for the applicants themselves, but for their entire families.[28] This is more than enough personal information for consumers to have their identities stolen.

We wanted to know who would be handling this information. Would the people handling this information receive background checks? If not, how can we be sure the people collecting this information haven't committed identity theft in the past? Would the data be secure once collected? Would the federal government be able to protect this personal information against security breaches that we see time and again?

Florida takes the safety of its citizens' private information very seriously. I want to thank Florida's Attorney General, Pam Bondi, for joining with 12 other attorneys general in a letter to HHS Secretary Kathleen Sebelius expressing concern about the failure to adequately protect the privacy of citizens seeking to enroll in the new exchanges.[29]

During the legislative session, we wanted to protect the private information of Floridians. We didn't want to pass overly burdensome or duplicate regulation on the navigators. Additionally, PPACA placed constraints on a state's ability to regulate navigators by requiring that state

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[28] Health Insurance Marketplace, Application for Health Coverage & Help Paying Costs, U.S. Department of Health and Human Services (2013), http://cdn.insuranceexchangehq.com/wp-content/uploads/2013/05/ObamaCare-Application-Form-Family-AttachmentC_042913.pdf.

[29] Patrick Morrisey et al., A Communication from the States of West Virginia, Alabama, Florida, Georgia, Kansas, Louisiana, Michigan, Montana, Nebraska, North Dakota, Oklahoma, South Carolina, and Texas Regarding Data Privacy Risks Posed by Programs Assisting Consumers with Enrollment in Health Insurance Through the New Exchanges, State of West Virginia, Office of the Attorney General (2013), accessed at http://myfloridalegal.com/webfiles.nsf/WF/JMEE-9AKRP2/$file/HHSLetter.pdf.

regulation may not "prevent the application of a provision of PPACA."[30] It is unclear and uncertain what requirements a state can place on navigators.

We passed a law in Florida that required the registration of navigators which included background screenings, disqualifications for certain crimes, and penalties for improper actions.[31]

During session, the navigator grants had not been awarded, the navigator rules had not been finalized, and the navigator training had not been announced. We didn't know, and frankly didn't expect, how little training and oversight the navigators received—or we would have passed an even more rigorous law in Florida.

PPACA itself only refers to "navigators." And Florida passed registration requirements for navigators. Now we find out that HHS has also created certified application assisters, certified application organizations, and Champions for Coverage—all of which appear to be expected to perform the same activates as navigators but with even less oversight.

PPACA's Medicaid Expansion Will Lead to Poor Care and Cost Overruns

The federal government has exerted great pressure on our state to expand Medicaid eligibility. Despite the fact that our Medicaid reform pilot had been widely hailed as a decided success, our request to implement those reforms statewide sat on the desk at the Centers for Medicare & Medicaid Services (CMS) for nearly two years. We submitted our request to implement those reforms statewide in August 2011, but didn't gain final approval until June 2013.[32-33]

Were our reforms held hostage to pressure us into expanding Medicaid? After all, HHS is continuing to push Medicaid expansion in our state.[34] Fundamentally, I believe the Medicaid expansion is a flawed approach to reduce the number of uninsured residents in Florida.

Rather than temporary assistance targeted to our most vulnerable residents, the optional Medicaid expansion would have created a new entitlement for able-bodied, working age adults without children.[35] This group has never been considered categorically needy and doesn't

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[30] Senate Banking and Insurance Committee, Bill Summary for CS/SB 1842, Florida Senate (2013), http://www.flsenate.gov/PublishedContent/Session/2013/BillSummary/Banking_BI1842bi_1842.pdf.

[31] Supra Note 18.

[32] Florida Agency for Health Care Administration, Statewide Managed Medical Assistance Program 1115 Research and Demonstration Waiver, Florida Agency for Health Care Administration (2011), http://www.fdhc.state.fl.us/Medicaid/statewide_mc/pdf/mma/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf.

[33] Centers for Medicare and Medicaid Services, Managed Medical Assistance Program Approval Letter, U.S. Department of Health and Human Services (2013), http://www.fdhc.state.fl.us/Medicaid/statewide_mc/pdf/mma/06-14-2013_Appproval_Letter.pdf.

[34] Daniel Chang and Kathleen McGrory, Feds to Florida: Not Too Late for Medicaid Expansion, Miami Herald (2013), http://www.miamiherald.com/2013/07/24/3519595/feds-to-florida-not-too-late-for.html.

[35] According to the Urban Institute, nearly 83 percent of the uninsured individuals made eligible by the expansion are working-age adults with no disabilities and no dependent children. The remaining 17 percent are working-age

qualify for other types of welfare, including the Temporary Assistance for Needy Families program's cash assistance.[35]

Across the nation, Medicaid programs already face major problems. Access to care is limited and outcomes are poor.[37-38] The only randomized, controlled trial of Medicaid ever conducted found no improvements in health when compared to the uninsured.[39]

We're already facing a provider shortage, both inside and outside of the Medicaid program. There is nothing in PPACA to significantly and permanently increase the number of providers. Expanding Medicaid to more than a million new individuals would undoubtedly make access problems worse. And those who would suffer most would be our most vulnerable residents, including our elderly population and those with disabilities. They would be forced to compete with able-bodied adults for a limited number of appointments.

But even if Medicaid were an efficient program, state lawmakers face another huge problem—we have no idea how much it would really cost. In Florida, we heard testimony on what happened in other states that had already expanded Medicaid to this group of people.[40-41]

We learned that in Arizona, enrollment was nearly three times what was expected and that costs were four times what was expected.[42] We learned within two years of Maine expanding Medicaid, nearly twice as many people signed up as the state thought were even eligible and uninsured.[43] We learned that in state after state that expanded, this new eligibility category cost far more than policymakers expected.[44]

We received plenty of cost estimates. But they were all highly sensitive to a number of assumptions—illustrating the general lack of experience and multitude of unknowns inherent in

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parents with no disabilities. See, for example, Genevieve M. Kenney, Opting In to the Medicaid Expansion Under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?, Urban Institute (2012), http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[36] Gene Falk, The Temporary Assistance for Needy Families (TANF) Block Grant: A Primer on TANF Financing and Federal Requirements, Congressional Research Service (2013), http://www.fas.org/sgp/crs/misc/RL32748.pdf.

[37] Supra note 4.

[38] Kevin D. Dayaratna, Studies Show: Medicaid Patients Have Worse Access and Outcomes than Privately Insured, The Heritage Foundation (2012), http://thf_media.s3.amazonaws.com/2012/pdf/bg2740.pdf.

[39] Katherine Baicker et al., The Oregon Experiment—Effects of Medicaid on Clinical Outcomes, New England Journal of Medicine (2013), http://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

[40] Senate Select Committee on PPACA, Committee Meeting Expanded Agenda: February 11, Florida Senate (2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2026.pdf.

[41] House of Representatives Select Committee on PPACA, Committee Meeting Notice: February 18, Florida House (2013), http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2738&Session=2013&DocumentType=Meeting%20Packets&FileName=PPACA%202-18-13-ONLINE.pdf.

[42] Id.

[43] Supra note 41.

[44] Supra note 42.

expanding Medicaid to such a large and unfamiliar population.[45] As we got more information over time, the projected costs of Florida's Medicaid expansion skyrocketed. Our official estimates on the total ten-year cost of expanding Medicaid went from less than $30 billion, as reported to us at a February 2013 committee hearing, to nearly $55 billion less than one month later—based on more realistic figures pulled from reports from CMS, Mathematica, and other states' Medicaid programs.[46-47] Florida's share of these costs more than doubled to $3.5 billion, up from the earlier $1.4 billion estimate.[48]

Even without expansion, Medicaid spending is crowding out funding for state priorities like education. More than 30 percent of our state budget goes to Medicaid.[49] A little over a decade ago, it was half that.[50] Expanding Medicaid would crowd-out even more of our resources. And even worse, it would prioritize our Medicaid resources on able-bodied, working-age adults, rather than on the most vulnerable.

All this assumes, of course, that the federal government is going to keep its funding promises. The federal government is already nearly $17 trillion in debt.[51] That's expected to grow to more than $26 trillion during the next decade.[52] Can the federal government afford to keep this promise? It couldn't afford to keep its promises to states on special education funding.[53] Or on the funding promised to states when we borrowed with Build America Bonds.[54] How many broken promises do we need to be on the losing end of before we recognize that grand promises such as this one are inherently suspect?

Florida decided not opt-in to the Affordable Care Act's voluntary expansion of Medicaid. That doesn't mean we won't be affected by the law. The law is still expected to add more than $82 billion in costs to our Medicaid system during the next decade.[55]

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[45] Jonathan Ingram, The Uncertainty of Medicaid Expansion, Foundation for Government Accountability (2013), http://www.floridafga.org/wp-content/uploads/1FINAL-The-Uncertainty-of-Medicaid-Expansion.pdf.
[46] Supra note 42.
[47] Senate Select Committee on PPACA, Committee Meeting Expanded Agenda: March 11, Florida Senate (2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2102.pdf.
[48] Id.
[49] Brian Sigritz, State Expenditure Report: 2011, National Association of State Budget Officers (2012), http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf.
[50] Nick Samuels et al., State Expenditure Report: 2000, National Association of State Budget Officers (2001), http://www.nasbo.org/sites/default/files/ER_2000.pdf.
[51] Bureau of the Public Debt, The Debt to the Penny and Who Holds It, U.S. Department of the Treasury (2013), http://www.treasurydirect.gov/NP/debt/current.
[52] Douglas W. Elmendorf, The Budget and Economic Outlook: Fiscal Years 2013 to 2023, Congressional Budget Office (2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf.
[53] Jonathan Ingram, Medicaid in Ohio: The Choice is Clear, Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/06/Medicaid-in-Ohio-The-Choice-is-Clear.pdf.
[54] Id.
[55] John Holahan, The Cost and Coverage Implications of the ACA Medicaid Expansion:

CONCLUSION

Thank you, Chairman Lankford and Chairman Jordan, for giving me the opportunity to share Florida's challenges with PPACA implementation. I share your goal of making quality, affordable, private health coverage accessible for all Americans—and I look forward to working with you to accomplish that goal outside of the constraints of the federal health law.

National and State-by-State Analysis, Kaiser Commission on Medicaid and the Uninsured (2012), http://www.urban.org/UploadedPDF/412707-The-Cost-and-Coverage-Implications-of-the-ACA-Medicaid-Expansion.pdf.

Mr. LANKFORD. Thank you.

Thank you to all of you for your testimony, both your written testimony and your oral testimony as well. We appreciate your participation in this.

I seem to get a feeling we have two different views today. The difficulty is one group is talking about the dream of what these benefits might someday do and what they might actually occur one day if everything works, and another group that is dealing with the reality on the ground of implementation and is not the dream of what might one day become, but what is currently right now and the problems we face.

We have a challenge dealing with this law, to say the least, but implementation is very often the State and the employer and the individual challenge, as every individual has to figure out some way to determine whether their employer has provided them qualified health care and determine what does that mean, or whether they qualify for a subsidy; and if they get that guessed wrong, they will be penalized on their income tax later for getting that guess wrong; or if their dad works somewhere and they take out insurance and get the subsidy, if they will be penalized because they took the subsidy that because their dad's employer should have covered them and all of that convoluted mess that has become this.

We cannot ignore employers like IBM. Walgreen's today, on the front cover of the newspaper, has shifted their insurance. Did not shift their insurance because they thought it was the right time, they shifted their insurance because they were dealing with the ACA. Unions continue to step up and say there are major problems and issues, we wish these would be addressed.

There is the dream of what we hope it will be and the reality of what is on the ground. We have the responsibility to deal with the reality on the ground, and to get questions and to be able to work through what is the solution at this point.

Attorney General Wilson, you wrote a letter August the 14th, with other attorneys general, and asked some very specific questions to HHS. Do you recall some of those questions and issues that you asked in August?

Mr. WILSON. Yes, I do. In fact, I have the letter here with me. I believe it was provided to the members of the committee, but we can provide that.

Mr. LANKFORD. We can have that in the record.

Mr. WILSON. Our concerns, and, again, I am not here today as an implementer, because that is not my role as attorney general. I am here as an attorney for the State, the citizens of South Carolina, and as a consumer advocate. And the questions we outlined in the letter dealt with screening of personnel, guidance to program personnel of the Navigator, so to speak, the monitoring of personnel.

Other areas of concern were who bears the liability; is it the exchange, is it the individual navigator, is it the sponsoring group that receives the grant funds? What notice to consumers are they going to get? Fraud prevention and remedies was another area that we asked questions under. We had questions about penalties, as well as supplemental State regulations; what can the States do,

without running afoul of preemption issues, in protecting our citizens.

So our questions, we sent this letter to HHS. We are still waiting on an answer.

Mr. LANKFORD. So no response at this point.

Mr. WILSON. No response at this point that I am aware of.

Mr. LANKFORD. Okay.

Lieutenant Governor, you seem to a person that is trying to obstruct something that is going to help people and take care of people. Yet you speak of taking care of people for free and caring for the folks. You also speak of $3400 just last week, an additional compliance cost in your office, and I can't imagine what that is multiplied around the Country of millions of dollars of additional compliance costs that has been added to it. My question for you is what could the State of Kansas do to take care of their people, or have they already done something to be able to take care of their people that need health care?

Dr. COLYER. This is not a simple answer. There is not just one single answer, but let me give you a couple of examples. The States of Kansas, unlike almost every other State, we have overhauled our entire Medicaid system. We did not throw anybody off our system; we did not cut rates. But we are able to save $1 billion. And by competing it out, we actually are giving everybody now three choices, where they didn't have choices before. And in that bidding process we actually got additional services for people and are starting to look at long-term health care outcomes.

In the State legislature we passed a bill that got rid of mandates so that people could have a choice on a more affordable insurance option now in the State of Kansas. We have worked on this in a whole variety of areas, medical homes, our indigent clinics, and working on this in a very comprehensive way.

Mr. LANKFORD. So there are State solutions that you are proposing on this.

Dr. COLYER. Absolutely.

Mr. LANKFORD. I am going to be real close on time, just to let everyone know, the five minute time. Because of the number and we have two different subcommittees together, I am going to try to stick right on the five minute time for questioning on that.

So, with that, let me recognize Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you, and I will abide by your time frame as well.

Let me just say I was very impressed to hear that the chairman of the full committee now is of the opinion that we should be fixing the Affordable Care Act, not repealing it. Unfortunately, I regret that he is not here right now because last year he was a cosponsor of H.R. 2, which was in fact a bill to repeal the Affordable Care Act. So he has had a change of heart, it appears, based on his comments today, and I am pleased to hear that.

Let me start by asking each of you do you receive health insurance as government employees through your States? Just raise your hand if you do.

So everyone except for the attorney general. You receive yours through TRICARE, is that correct?

Mr. WILSON. That is correct.

Ms. SPEIER. All right. I know why you receive it through TRICARE, because with TRICARE, which is what my brother has, you pay $500 a year for health care. It is pretty remarkable that that insurance is available.

Mr. JORDAN. Would the gentlelady yield for a second?

Ms. SPEIER. No, I am not going to yield. I have very few seconds in my opportunity, so I think we are all just going to be able to ask our questions.

So let me ask you all this. The presentations that you have provided today, particularly the Republican representatives, were pretty remarkable in that they were elaborate, they were footnoted. And I am curious when were you asked by the committee to participate in this hearing.

Dr. COLYER. About Wednesday or Thursday of last week. I think Thursday.

Ms. SPEIER. Okay. Attorney General?

Mr. WILSON. A week or two ago.

Ms. SPEIER. A week or two ago. All right.

And Secretary Kliebert? Thursday?

Ms. KLIEBERT. Thursday.

Ms. SPEIER. And Representative Hudson?

Mr. HUDSON. Mid last week, Wednesday or Thursday.

Ms. SPEIER. Mid last week.

So pretty impressive that you have been able to put together those kinds of statements with footnotes. I mean, that is something I did when I was in college, and I didn't do it very well. I guess my question to you is did any of you have any assistance; anyone help you develop your statements?

Dr. COLYER. Sure. Actually, Ren, my staffer, and our staff, we were literally working at this footnoting this at 1 a.m. on Monday morning.

Ms. SPEIER. All right. Thank you.

Attorney General Wilson?

Mr. WILSON. Yes, my staff and I prepared the remarks.

Ms. SPEIER. All right.

Secretary Kliebert?

Ms. KLIEBERT. Yes, certainly. My staff that is involved in the implementation and involved in our Medicaid program helped, as well.

Ms. SPEIER. Representative Hudson?

Mr. HUDSON. Yes, Florida House Health Policy staff.

Ms. SPEIER. All right. To your knowledge, did any of them do this in conjunction with ALEC, the American Legislative Exchange Council? They are very similar, many of them drafted in a way that would suggest that there was collaboration.

Dr. COLYER. No.

Ms. SPEIER. No?

Mr. WILSON. Not to my knowledge, no.

Ms. KLIEBERT. No.

Mr. HUDSON. No.

Ms. SPEIER. All right. Thank you.

Let me then move forward with the one minute and 33 seconds that I have left and ask a couple of questions. Bobby Jindal, who is the governor of Louisiana, recently said, "We don't think it

makes any sense to implement Obamacare in Louisiana. We are going to do what we can to fight it."

Ms. Jackson, in your opinion, is it a significant challenge to the ACA implementation when the chief executive of a State is so strong-willed in their commitment and interest in not implementing the law of the land?

Ms. JACKSON. It has been one of the most difficult challenges. Passed himself as an elected official, basically attempting to prohibit the implementation. Every letter sent to the Department of Health and Hospitals from any Health and Welfare Committee member or any legislature has been met with delay, and sometimes we have been told that it was not part of the public records request.

It is also difficult, if I can, when you have a secretary of Department of Health and Hospitals, with all due respect, who has only been there six months and trying to implement a major privatizing of our Medicaid-Medicare program as we speak, along with attempting to obstruct this implementation.

Ms. SPEIER. I thank you, and my time has expired.

Mr. LANKFORD. Thank you.

Chairman Jordan.

Mr. JORDAN. I thank the chairman.

Let me just start first with the reason I asked if the gentlelady would yield is my guess is, and the attorney general can speak for himself, but my guess is the reason he has TRICARE is because he wore the uniform of our Country and served our Nation. I believe even served in combat, is that correct, attorney general?

Mr. WILSON. Yes, correct.

Mr. JORDAN. Well, we appreciate your service, and you are simply getting what you are entitled to.

Lieutenant Governor, let me start with you. You are a physician and elected State-wide. Do you think it makes sense to delay the Affordable Care Act?

Dr. COLYER. Yes, it does.

Mr. JORDAN. Okay.

Attorney General Wilson, you represent an entire State as well. Your job is to look out for consumers. You have asked questions of HHS and CMS; they have yet to answer your questions. Do you think it makes sense to delay the Affordable Care Act?

Mr. WILSON. From a security and privacy interest standpoint, I do. One other comment, I would like to know what plan under TRICARE allows me to pay $500 a year, because I pay nearly $200 every month.

Mr. JORDAN. Your wife would probably like to know that too.

Mr. WILSON. My wife wants to know where we get that plan.

Mr. JORDAN. Let me go to you, then, Senator Hutto. So based on what you said in your testimony, you probably disagree with the guys on either side of you. You think that the Affordable Care Act should move forward and the law should go ahead and be fully implemented, is that correct?

Mr. HUTTO. That is correct. I won't tell you that it will be seamless.

Mr. JORDAN. Let me ask you a couple questions. Let me ask you a couple questions. Was Howard Dean wrong when he said the

Independent Payment Advisory Board is essentially a health care rationing body? Was he right or wrong when he said that about the Affordable Care Act?

Mr. HUTTO. I don't think it is going to be a rationing body, no.

Mr. JORDAN. Was head of the Teamsters, James Hoffa, wrong when he said that this law is going to hurt working Americans and fundamentally change the 40-hour work week? Was he wrong?

Mr. HUTTO. I think he was.

Mr. JORDAN. He didn't know what he was talking about?

Mr. HUTTO. We are going to have to work through this.

Mr. JORDAN. Was AFL–CIO wrong last week, at their convention in Los Angeles, where they said fix the bill or repeal the whole darn thing? Were they wrong?

Mr. HUTTO. Yes.

Mr. JORDAN. They are wrong too. Okay. Was Senator Baucus, a guy who helped write the bill, head of the Senate Finance Committee, pretty accomplished public servant, was he wrong when he referenced that this bill was a train wreck?

Mr. HUTTO. That was taken out of context, but yes.

Mr. JORDAN. He was wrong too. Okay. And Warren Buffett yesterday, probably most people would said a fairly sharp individual, made a few dollars in his life, was he wrong yesterday when he said we should scrap the entire bill?

Mr. HUTTO. We have to fix the bill.

Mr. JORDAN. Was he right or wrong? So far everyone has been wrong and you are the only one who has been right.

Mr. HUTTO. That is not what I am saying. What I am saying is that we need to work together.

Mr. JORDAN. The President's hometown newspaper, three weeks ago, lead editorial, final paragraph of the editorial said, delay the entire law. Chicago Tribune endorsed the President both times he ran for the President. Were they wrong when they said delay the entire bill?

Mr. HUTTO. That is their opinion.

Mr. JORDAN. Their opinion. But I am asking you were they right or wrong.

Mr. HUTTO. I think they were wrong.

Mr. JORDAN. This is amazing. We need to have you up here more often, because you are right and everyone else is wrong. Let me ask you this. Do you still say this bill should be implemented when Kroger, a major employer in our State, announced last week that 11,000 employees and their spouses would no longer be covered by their insurance? Is that a good thing? Is that a good result for the Affordable Care Act?

Mr. HUTTO. That is not a good thing, but I am sure there are alternatives.

Mr. JORDAN. United Parcel Service announced recently that 15,000 workers and their spouses and families would no longer be covered. Is that a good thing?

Mr. HUTTO. It is going to be a good thing when hundreds of thousands of new people are covered.

Mr. JORDAN. Let me just turn to the attorney general. You deal with protecting consumers in your State, so when a company offers a product and they have a guarantee, and someone purchases that

product and the guarantee is not met, the consumer gets a chance to take the product back and get something new or get their money back.

But what we have here is we have the guarantee that if you liked your insurance, you would be able to keep it. And we just know Kroger, UPS, University of Virginia, Trader Joe's, and I could name a whole bunch of other companies, are now telling people because of the Affordable Care Act you will no longer be able to keep the product you thought you were going to be able to keep. That, to me, if for no other reason, that is why we should delay it, because the guarantee that the President said and everyone who supported this bill said was going to be in place is no longer in place. Would you agree?

Mr. WILSON. Yes.

Mr. JORDAN. All right.

Mr. Chairman, I yield back.

Mr. LANKFORD. Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

And thank you to all the witnesses who came here today to share your expertise and your insights on the implementation of the Affordable Care Act. An exciting time in America. October 1st is time to start getting signed up for the health care law. To make sure we get the word out, it is Healthcare.gov. Get right on there, enter your information. It is going to be easy and it is going to be interesting, and it is a new dawn in American health care.

I want to start with you, Attorney General Wilson, and I want to thank you for correcting my misstatement. You work with Governor Nikki Haley, not under her, and I appreciate that. In fact, I also want to thank you for your military service. I don't care if you are Democrat, Republican, pro-ACA, anti-ACA. If you deliver military service like what you did, you deserve the thanks of all of us.

And I want to expand on our discussion of Governor Nikki Haley. Were you attempting to distance yourself from her remark about the importance of de-funding Obamacare in Congress? Were you trying to get away from that remark?

Mr. WILSON. No, representative. What I am trying to do is I am trying to appear today here, I am an elected official, but I am trying to wear the State's lawyer hat. I fought Obamacare in the court all the way to the U.S. Supreme Court. In fact, the Supreme Court agreed with the States and NFID on every issue we presented except for the fact whether the mandate was a tax or penalty. But we lost the fight, so now, if it is the law of the land, my job is now, as the lawyer for the citizens of South Carolina and as a consumer advocate, to ensure that their information is protected.

Mr. CARTWRIGHT. Well, general, you are a prosecutor. You know what a yes or no question is. Yes or no, do you agree with Governor Haley when she says everybody else in Congress needs to de-fund Obamacare?

Mr. WILSON. I believe it is good policy, yes.

Mr. CARTWRIGHT. You agree with that. And is that why, when you were engaged in the fight in the Supreme Court, arguing that the ACA is unconstitutional, is that why you made the public com-

ment publicly comparing the ACA to committing robbery? Is that why you did that?

Mr. WILSON. I don't recall that comment. I don't dispute that I made it, but I don't recall it.

Mr. CARTWRIGHT. All right, I want to switch over to you, Senator Hutto. You made the comment that my brother, Congressman Jordan's quote of Senator Baucus was taken out of context. Congressman Jordan has not been bashful about doing that, talking about the train wreck. The full context was that Senator Baucus said, and meant, that if the ACA is not implemented properly, the way it is meant to be done, it could turn into a train wreck. Is that your recollection?

Mr. HUTTO. Absolutely. And I think what he is saying is we need to work together to make sure it is fully implemented correctly.

Mr. CARTWRIGHT. Thank you, sir.

I want to jump over to you, Senator Sobel. It is a pleasure to have you here, Senator. All the things that you have done to help seniors and health care in Florida. I want to remind everybody that Senator Sobel has been talked about by the South Florida Sun Sentinel as "a strong voice in Tallahassee for education, health care issues, and senior citizens services." So welcome. Nice to have you here, Senator.

You have heard about what we have been talking about here. This hearing is about challenges facing ACA implementation. This week it was reported that, in Florida, Governor Scott issued a directive banning Navigators from operating on the grounds of county health departments in Florida. Senator Sobel, in your opinion, was this move intended to obstruct implementation of the Affordable Care Act?

Ms. SOBEL. Yes, I believe so. These health departments have the kinds of people that actually need health care; they go to these health departments because they don't have a private physician, they don't have health insurance. And by not allowing them on the property, and some of these properties are owned by counties, by the way. Broward County owns its own properties, so they worked out a compromise that they could work outside and sign people up. But that is not good enough because you cannot get to people who don't show up on that day, but showed up in the past. And this is a tremendous group of people who desperately need health care, and Governor Rick Scott is denying them that access and information.

Mr. CARTWRIGHT. Thank you for that.

I yield my time.

Mr. LANKFORD. Thank you.

Chairman Issa.

Mr. ISSA. Thank you, chairman.

General Wilson, I heard your testimony. I apologize, we have a classified briefing going next door on another program of interest, but you said something a moment ago: this is the law of the land, right? But you have an opinion that there are some aspects of this law that were defective in how they did things, and let me just run you through one of them.

Under the Act, currently, my State, Ms. Speier's State, Medicaid, the poorest of Medicaid recipients, it is a 50/50 deal; the Federal

Government throws in 50 percent on Medicaid, the State pays 50 percent. Under the Affordable Care Act, for the first three years it is 100 percent paid for by the Federal taxpayer; afterwards, it is supposed to go to 90 percent.

Now, isn't it a legitimate concern of States that a promise to pay more for less poor people, less needy people at 90 percent, where the more needy people are being reimbursed at 50 percent, and 100 percent for the first three years, is inherently likely unsustainable; that in fact the bargain in the Act that we had to pass before we could read it created a situation in which some of these things are simply not believable? Is that correct in your assumption?

Mr. WILSON. That is correct.

Mr. ISSA. And in your State of South Carolina wasn't that one of the reasons that the governor had concerns, is that it is all going to be sugar from the Federal Government for the first three years, and then after that it is at the whim of Congress that is borrowing a trillion dollars a year, right?

Mr. WILSON. That is correct.

Mr. ISSA. Now, in the case of the recent release of 2400 personal social security numbers, even before the Act was implemented, isn't that one of your concerns, that this highly personal information, the question of what your social security number is, but the question of whether or not you are being treated for venereal disease or you have a persistent illness of some sort or whether you are a diabetic, all of that is exactly the kind of information that you are charged to make sure does not become public, since that is historically private information.

Mr. WILSON. Yes, that is correct.

Mr. ISSA. Now, the conversation about people coming into county health centers and so on, isn't compliance with HIPAA, making sure that only doctors and cleared medical professionals have access to this kind of information, as to what you or I or anyone else is receiving by way of medical concern, isn't that a legitimate concern of letting basically a salesman into a hospital or clinic facility?

Mr. WILSON. That is correct, and that is a concern I had about HIPAA not applying to potential navigators that are helping people enroll in the exchange.

Mr. ISSA. But these navigators will in fact be gathering exactly the information that HIPAA is supposed to prevent from going into people not very specifically cleared, true?

Mr. WILSON. It is very potential, yes.

Mr. ISSA. Well, Ms. Speier perhaps paraphrased what I said, and I want to make sure we get it correct here. I think that the Affordable Care Act currently will be a train wreck. It doesn't answer serious questions about cost and privacy. Now, I was saying, and, Ms. Speier, I want to make sure I am clear, there were problems when President Obama came in that had not been addressed; rising cost of health care, an interesting cliff that causes people to choose to not earn more than a certain amount, because if you earn less than a certain amount in America you have $20,000 or $30,000, maybe $40,000 worth of benefits that come to you. When you earn a little more, you lose those benefits. The Affordable Care Act, in my opinion, even exacerbates that more because of the nature of the means testing and so on.

So do I want to address the issues of cost of health care, access of health care? Absolutely. And I would make it clear, and any member on the dais can get more information from our staff, we have been working on a change to FEHBP to make it compliant with the exchange systems, if you will, that are envisioned in the Affordable Care Act. We are responding to, at least as to the 2.4 million Federal workers and the 8 million covered individuals, the reality of a law.

But don't confuse my votes repeatedly to repeal as either only wanting to repeal or somehow not being against the Affordable Care Act. I believe that a bill that was 100 percent partisan, voted on without a single Republican vote or any real input, that we had to pass it before we could read it, and that has material flaws which are numerous in fact is a bill that should be started over again.

Having said that, I appreciate our panel and I am going to continue to hear what you have to say. I would note, because the ranking member is not here, that I want to thank all the witnesses. I have checked, and all of you came here without the Federal Government paying you a dime to come here. So since you all came on your own dime, I would like to add to the list the thank you.

With that, Mr. Chairman, I yield back.

Mr. LANKFORD. Mr. Cardenas.

Mr. CARDENAS. Thank you very much, Mr. Chairman.

My first question is to Mr. Hudson. In your submitted testimony you stated, "These provisions require insurance companies to accept all applicants, even if they wait until they get sick before applying for coverage, and the insurance companies are now prohibited from charging premiums based upon likely costs." Is that accurate?

Mr. HUDSON. Thank you. Yes.

Mr. CARDENAS. Okay. Are you referring to the guaranteed issue and community rating provisions of the Affordable Care Act?

Mr. HUDSON. Yes.

Mr. CARDENAS. Okay. Thank you for clarifying that. Personally, I can't understand why you would oppose these important consumer protections in the Affordable Care Act. A recent analysis by the Department of Health and Human Services estimates that between 50 million and 129 million non-elderly Americans have some kind of preexisting condition. Without the guaranteed issue and community ratings protections in the Affordable Care Act, these preexisting conditions would put them at risk of not being able to obtain health insurance if they are self-employed or experience some other change in life circumstances.

I think, for example, we heard the story of Aqualine Laury, she was here earlier, which Ranking Member Cummings described in his opening statement, as illustrative of the importance of these consumer protections in the Affordable Care Act. Due to a preexisting condition, a heart condition that she had suffered from since 1990, Ms. Laury has been unable to obtain consistent health care coverage since 2005.

In 2005, when her insurer rescinded her coverage and left her with a $50,000 medical bill. Thankfully, she was able to obtain insurance through a high-risk pool established by the Affordable

Care Act and was covered when she had a heart attack this past May. I am grateful for that. She is able to be here with us today.

Another question, Mr. Hudson, in the State of Florida, if somebody suffers a heart attack and they do not have insurance, what is the likely scenario from that moment forward? I would assume that if somebody has a heart attack and somebody witnesses it, let's just say an ambulance shows up, what is the likely scenario after that, when the ambulance shows up and tries to attend to somebody without insurance who just had a heart attack?

Mr. HUDSON. Thank you for the question. I would assume it would be the same in your great State of New Mexico.

Mr. CARDENAS. No, I am from California. Continue.

Mr. HUDSON. California. Excuse me. Where, frankly, EMS would try and revive that person to the best of their skills and ability, and they would transport that person to a hospital. In my State, that is prohibitively challenging, as I have eight counties without hospitals.

Mr. CARDENAS. Okay. Now say that person was fortunate to arrive at a hospital and then their condition was in fact adhered to, say they revived that person, say that person had some kind of surgery or what have you, then there comes a big list of expenses. What would happen to that list of expenses when that person without insurance ended up showing up at the hospital due to a heart attack, then what would happen with the bottom dollar, the bottom line of that expense? What would likely occur with that expense, would the State eventually end up picking up some of that cost, perhaps the hospital would absorb a portion or all of that cost? What is the likely scenario?

What committee are you chairman of in the State Senate in Florida?

Mr. HUDSON. It is the State House, and it is Health Appropriations.

Mr. CARDENAS. Okay. So what would likely happen to that dollar amount, whether it is $40,000, $80,000, $120,000, whatever?

Mr. HUDSON. Likely what would happen is that patient would be treated, would be stabilized under your Act of EMTALA, and then sent home after they had been stabilized. The cost of the care could be incorporated under charity care through that particular hospital, it could be facilitated by DISH funds or low income pool funds.

Mr. CARDENAS. Okay. So to my point, ladies and gentlemen, the Affordable Care Act is trying to find a solution to all of those situations in the great State of Florida and the great State of California, and every State in the Nation, what the Affordable Care Act is trying to address, and that is the overall cost and who will bear that cost at the end of the day, and trying to provide a system that actually is better than the system that we have today, because I know exactly what happens when that occurs; the person who actually had the heart attack does not bear the burden of that and the insurance companies in the State of Florida or California do not inherently bear that burden, it will eventually be a taxpayer system that will bear that burden and/or a private or public hospital that actually adhered to that patient who suffered a heart attack and got administered some health care.

So what we need to understand, ladies and gentlemen, and I will end quickly, Mr. Chairman, thank you so much, is that the Affordable Care Act is trying to transition into a system that is more appropriate for this great Country to address the ills, the health care ills of all Americans, and the current system leaves 50 to 129 million out because they have preexisting conditions, and those people with preexisting conditions who don't have health care will end up in the system and costing American taxpayers even more.

Thank you very much, Mr. Chairman.

Mr. ISSA. Would the gentleman yield? Would the gentleman yield?

Mr. CARDENAS. My time has expired.

Mr. LANKFORD. His time has expired, but I will extend 30 seconds to you.

Mr. ISSA. Just quickly for a question. So if I understand correctly, the Affordable Care Act, which costs hundreds of billions dollars of taxpayers' money replaces the idea that taxpayers pay money. Didn't you make essentially the point that the taxpayer is going to pay it under the Affordable Care Act involuntarily and the taxpayer is already paying it? People are not failing to get care, under the Affordable Care Act you simply have taxpayers paying for the insurance in addition to paying for somebody if they go to the hospital.

Mr. CARDENAS. That is an interesting interpretation. That is not what I said. At the end of the day, under a new system, if we implement the Affordable Care Act properly, what we are going to have is more Americans with health care coverage and true access to health care, unlike what we have today. Thank you.

Mr. LANKFORD. The challenge is even CBO has said at the end of it, full implementation, we will still have about 31 million Americans still not covered.

Mr. CARDENAS. With an M, not a B, right? Thirty-one million Americans?

Mr. LANKFORD. Thirty-one million, yes.

Mr. Woodall.

Mr. WOODALL. Thank you, Mr. Chairman, and thank you all for coming.

I am from the great State of Georgia. This is my insurance commissioner that you see up there on the wall. And candidly, Mr. Chairman, I couldn't tell if that was you or the ranking member who put that up there, because what I am going to tell you will not surprise you at all. Ralph Hudgens, our insurance commissioner, love Georgians. He loves people and he cares about people, which is why he got involved in public service and ran to be our insurance commissioner. It is a constitutional office in our State, insurance commissioner, and what he said there is we talk about how to get coverage for Georgians, how to get affordable care for Georgians, and he said Obamacare is actually the problem and I am going to do everything I can to obstruct it from creating those problems.

I have a high deductible medical savings account. My policy was outlawed by the President's health care bill. Now, I can afford to buy a more expensive policy, but a lot of folks in Georgia who relied on those high deductible policies can't afford to buy something.

What I wanted to ask you all, representing different States and different opinions, what is it in the President's health care bill that you like, that is going to be valuable for your constituents back home, that you and your State, with your governor, with your legislature, with your insurance commissioner, that you all couldn't have done on your own if you thought it was the best plan for your State? What is it that you needed the benevolence of the Federal Government for? What permission did you need from Washington to implement some of these things that are really going to pay off for your constituents back home?

If I could start with you, governor.

Dr. COLYER. Nothing. I mean, solutions are best where it is local, and all of our States have different problems and different solutions. We have a number of solutions that we could do here in the State. It is all of these regulations that are there. Sure, we would like to have the money in the State so that we could implement some things there, but there are so many strings attached that it really gets in the way of a lot of things that prevent us from getting better outcomes.

Mr. WOODALL. Senator, let me ask you. I actually went to school in South Carolina. My understanding is the very modest health care plan that I had in college is now outlawed as well, so students will no longer be able to have that. But what is it that South Carolina is going to benefit that you all couldn't have done in the senate with your governor and your insurance commissioner?

Mr. HUTTO. What we are looking forward to is not using the emergency room as the medical home for so many people, and the money that we are going to get from the Federal tax dollars that our citizens pay coming back to us is going to help us implement that.

Mr. WOODALL. I talk about that regularly. I don't have any dollars to spend except the dollars your constituents send to me and that I turn around and give back. I am pretty sure we take a cut off the top, but I am glad that folks see that as a glass that is half full, that some of those dollars will come back.

Mr. Attorney General, is there anything that is going on in South Carolina that you needed the Fed's permission in order to implement?

Mr. WILSON. I am a strong federalist. I believe that the problems can best be solved by the States, with a few exceptions. But I have looked at the numbers. It has been a year, but it would have been cheaper for the Federal Government just to cut a check to every American who didn't have health insurance, as opposed to basically create this huge goliath of a bill. It would have been cheaper just to write a check and give it to people without insurance than do this.

Mr. WOODALL. That is the way my math looked, too, Attorney General. Though, in fairness, President Clinton and Newt Gingrich, Republicans and Democrats, came together in 1996 with HIPAA to solve all of these preexisting problems for federally regulated plans. We just said at that time States are pretty smart folks, they have smart people running those programs, so we won't get into their business.

I would ask you, Ms. Jackson, in 1996 we said let's leave it to the States, the States will love their constituents more than we do. Is there something that you were unable to do to serve your constituents that you needed our permission from Washington to get done?

Ms. JACKSON. Of course, if you had heard any of my testimony today, I talked specifically about our State governor and the Department of Health and Hospitals advocating for cutting hospice care for those uninsured patients. We couldn't even provide hospice care. And to the extent that we were trying to regulate interstate commerce, then, of course, you know the States are limited on their regulation of interstate commerce, which are most insurance companies; and that argument has been made at the Supreme Court.

Mr. WOODALL. So when you are thinking about what you can and can't do in Louisiana, you are saying you all don't have enough money to get these things; you are counting on us taxing other Americans and you will be getting more than your fair share?

Ms. JACKSON. Oh, not at all, sir. What we count on is that the money we send to the Federal Government that our taxpayers in Louisiana pay would be distributed in a manner that we can take care of all citizens in our State, just like other States count on that as well. But we do pay Federal taxes, and to that extent we are afforded, or should be afforded, our rightful share of those Federal taxes, and that is the problem.

Mr. WOODALL. There is no question about that, and I suspect that is something you will find good bipartisan support on.

Madam Secretary, is there something that Louisiana really needed the Fed's permission to get done?

Ms. KLIEBERT. I don't think anybody could be more passionate than myself about providing uninsured care for our citizens. However, I believe several things: one, we have done a very good job providing uninsured care. We have had a State charity system. We have recently changed that to a public-private partnership, which has eliminated a two-tiered system for the uninsured. We don't use the emergency rooms as our medical homes; we have opportunities for people to receive outpatient care, as well as follow-up care after they have received inpatient care, if needed, for every uninsured person in our State.

I actually believe that implementation of the Affordable Care Act will be detrimental to those that we are trying to help in the long-run.

Mr. WOODALL. That is what we believe in Georgia, as well, but I look forward to sharing our ideas with you all and you all sharing your ideas with us. I am convinced if we have 50 different projects going on here, we are going to find at least one that successfully serves America, and we can implement it.

Ms. KLIEBERT. We definitely would love to have flexible and outcome-driven health care, and we believe that we can do that within the system that we have without having the complications of the implementation of that.

Mr. WOODALL. Thank you, Madam Secretary.

Thank you, Mr. Chairman.

Mr. LANKFORD. Thank you.

Representative Duckworth.

Ms. DUCKWORTH. Thank you, Mr. Chairman. I would like to yield my time to the gentleman from Pennsylvania, the ranking member of the Subcommittee on Economic Growth, Job Creation and Regulatory Affairs, Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Congresswoman Duckworth.

Senator Sobel, I want to return to you. You are from Florida and I am from Pennsylvania. In my home commonwealth we have a figure of uninsured citizens of almost 12 percent. That pales in comparison to the 25.3 percent uninsured in your State, so obviously, in your position, with your set of values, this is something that you have been worrying about, something you have been working on for many years, am I correct in that?

Ms. SOBEL. Yes, sir.

Mr. CARTWRIGHT. So I want to follow up. Senator Sobel, do you believe that your Governor Scott is investing the resources necessary to ensure that Florida residents have the information they need to enroll in affordable quality health care in the Affordable Care Act exchanges?

Ms. SOBEL. Thank you very much for that very good question. I don't believe that there has been anything budgeted or used by the governor to inform people about the Affordable Care Act.

Mr. CARTWRIGHT. So we all know that getting on Healthcare.gov is easy enough for young people, but you have some folks in Florida that may not be as facile with computers. They are the people that need us to go the extra mile to make sure they understand how to sign up. Is the Florida administration doing everything it needs to be doing to help those people?

Ms. SOBEL. The Florida administration is not, to my knowledge, doing much or anything to educate the people about this program, and I believe the best way to kill a program, destroy a program is not to get the information out to the people who actually need that information. So it has become a formidable task to make this program a success and to have the people get the health care that they need in a way that they understand it.

Mr. CARTWRIGHT. So let's you and I give Governor Scott some help, shall we? Tell us, what should Governor Scott be doing to ensure that implementation of ACA, the law, goes smoothly?

Ms. SOBEL. Well, first of all, I think that he should allow the health departments to allow the navigators on the premises and to work with the people in the health department. I also think that he should be establishing a website probably in the State, which we might have one, but nobody knows about it, telling people about the Affordable Care Act. I believe that he should be speaking about it in his conferences, press conferences, as well as sending out information that is now available. None of that is happening.

Mr. CARTWRIGHT. Now, switching gears for the moment, the rate review provisions in the ACA require insurance companies to justify any proposed rate hike of 10 percent or more. Last year, this provision saved 6.8 million consumers in this Country an estimated $1.2 billion in health insurance premiums. Unfortunately, in Florida, the legislature recently passed, and Governor Scott signed, legislation stripping Florida's insurance commissioner of the authority to review health insurance rate hikes.

Congressman Joe Garcia, my colleague, has called this move "a cynical attempt to undermine protections for Florida's consumers in order to sabotage the implementation of the Affordable Care Act."

Senator Sobel, do you agree?

Ms. SOBEL. Yes, I do agree with the handcuffing of our insurance commissioner. At this particular time, he can only, well, first of all, previously, he could have negotiated the rates. Right now he can't say anything or do anything for the next two years.

Mr. CARTWRIGHT. So what is the point of just doing this giveaway to health insurance companies?

Ms. SOBEL. Well, I think the underlying premise here is that the rates will be so high people will not sign up, and you lose the affordable in the Affordable Care Act, and that is wrong. But the insurance commissioner has indicated, and rightfully so, that there are tax credits to be had, so the 30 to 40 percent rates that he is talking about, of an increase, will be mitigated with the tax credits people will get for signing up, but the headlines are 30 to 40 percent.

Mr. CARTWRIGHT. And it is misleading. Well, thank you very much, senator.

Mr. LANKFORD. Thank you.

Mr. Bentivolio.

Mr. BENTIVOLIO. Thank you, Mr. Chairman. Mr. Chairman, the committee has obtained an internal memorandum from May 28, 2013, detailing serious concerns about the ability to certify and register Navigators and Assisters in the Obamacare Consumer Outreach Program. The memo reads: We are becoming increasingly concerned about the ability of CMS staff to authenticate, register, and certify everyone who will be involved in the consumer assistance process.

I would like to enter this memo in the record.

Mr. LANKFORD. Without objection.

Mr. BENTIVOLIO. Later, though, another top official testified that HHS decided to leave the responsibility of certifying and registering to each Navigator organization. HHS rejected the option of creating a list of all certified Navigators and Assisters. The lack of a list exposes consumers to significant risk, since consumers that call the HHS hotline will be unable to verify if a person offering to provide them information about Obamacare is working for a legitimate organization.

Were you aware that there is no way for citizens in your State to contact HHS to verify if a person offering information about Obamacare is working for a legitimate organization, Lieutenant Governor?

Dr. COLYER. That is a very troubling aspect because there is going to be a lot of confusion overall, and we need good information, and you need time to get good information there and you need to be able to verify that.

Mr. BENTIVOLIO. Attorney General Wilson?

Mr. WILSON. Yes.

Mr. BENTIVOLIO. Secretary of Health Kliebert?

Ms. KLIEBERT. Yes.

Mr. BENTIVOLIO. Mr. Hudson, are you aware of a poll that was released last week, 68 percent of Americans believe Obamacare will

harm their health care, 56 percent of Democrats believe Obamacare will harm their health care? Are you familiar with that poll?

Mr. HUDSON. Yes, sir, I have seen the headlines on that.

Mr. BENTIVOLIO. Okay. I have another question. I am just going to twist things around a little bit. You said you were a realtor, correct?

Mr. HUDSON. Yes.

Mr. BENTIVOLIO. Okay. Now, if I understand a realtor's job, you bring a customer in, they are thinking of buying a home, you talk to them, find out what kind of home they want, you look at the listings, you show them the listings, maybe a photograph, correct? You ever sold a home to somebody?

Mr. HUDSON. Yes, sir, I have sold many homes to first-time home buyers.

Mr. BENTIVOLIO. How about somebody that never walked into the home you sold them? Did they get to look at all the rooms? Did they get to go in the basement, if you have basements? In Florida, I don't know, I think they are on slabs, a lot of them, right?

Mr. HUDSON. Basements are a challenge for us.

Mr. BENTIVOLIO. Basements are a challenge. Yes, I understand. Okay, well, in Michigan we have basements. So before a person buys, they get to walk in and go into each room, maybe test the appliances, correct?

Mr. HUDSON. Yes, sir.

Mr. BENTIVOLIO. Okay.

Mr. HUDSON. In fact, if I can add, I would never sell a home to someone that didn't know what they were actually bargaining for, because, frankly, that is one of the single largest investments in their life, their personhood, their entire family, and doing so is reckless and inappropriate.

Mr. BENTIVOLIO. And before they buy that home you give them the documents, you go over the purchase agreement with them, you tell them what they are getting, right, and what they are not getting, correct?

Mr. HUDSON. That is absolutely correct, as well as a number of other disclosures that will help them fully understand their purchase so that they are well informed and knowledgeable. The days of caveat emptor are gone, and should be under the Affordable Care Act as well.

Mr. BENTIVOLIO. So you would let your customers read the contract before they signed it, correct, or at least have their attorney or a representative read the contract, correct?

Mr. HUDSON. You are absolutely correct, sir.

Mr. BENTIVOLIO. But, senator, you disagree with that. You think we should, as legislators, vote for something that we didn't have the opportunity to read before we voted for it.

Mr. HUTTO. No, but there has been plenty of time now. It is a complex law and it is going to be tough. We need to roll up our sleeves and implement it.

Mr. BENTIVOLIO. So I have a bill on th floor right now, or not on the floor, but in the hopper, that basically is called Read the Bill's Act. You wouldn't be a cosponsor, but I suspect you would be, correct?

Mr. HUDSON. Absolutely, sir.

Mr. BENTIVOLIO. Thank you very much.

I yield back my time, Mr. Chairman.

Mr. LANKFORD. Would the gentleman yield to me? I think we had 20 seconds or so. Would the gentleman yield?

Mr. BENTIVOLIO. I yield.

Mr. LANKFORD. Just for Ms. Kliebert, you had mentioned before, as well, about conflicting messages on pregnancy as a life event. Has that been resolved yet, or are you still waiting for details on that?

Ms. KLIEBERT. We are still waiting for details. And it really affects us because our policy decisions in terms of how we will treat that population, it affects how we will move forward on that policy. But we have not heard back.

Ms. SPEIER. Would the gentleman yield?

Mr. LANKFORD. It is actually the gentleman's time. Mr. Bentivolio? Would the gentleman yield to the gentlelady?

Mr. BENTIVOLIO. Yes.

Ms. SPEIER. To the secretary, isn't the reason why there is not a willingness to allow someone to acquire insurance once they know they are pregnant because we don't want people to game the system and not access the insurance when the insurance is available to them, and they choose, instead, to just pay the tax?

Ms. KLIEBERT. I am not sure in terms of the rationale. All we want is an answer as to whether or not that is or is not a qualifying condition so we can make our policy decision on that.

Ms. SPEIER. But since there is an individual mandate of everyone actually takes up the insurance, then there wouldn't be an issue about a life-changing event because, in fact, you would already have insurance. The only time it would play a role would be if in fact you chose not to take insurance and, instead, pay the $300 fee, correct?

Ms. KLIEBERT. Correct.

Mr. LANKFORD. So it is not the gentlelady's position that we wouldn't give some kind of prenatal care at that point because someone didn't pay the penalty.

Ms. KLIEBERT. Correct.

Ms. SPEIER. No. I think, though, the point is that an individual mandate is trying to make sure that we all take personal responsibility. That is one of the precepts of the Republican party, personal responsibility. We are going to provide a health care opportunity for every American to access health care, and we are going to keep the cost down, but if you choose not to, and this is a free Country, if you choose not to, then you can pay a fee, which would mean that you are not going to access that health care. But that is a choice.

So if in fact you do become pregnant, then you are going to be paying out of pocket. We, of course, want you to have prenatal care. If you are indigent you will get prenatal care. But if you are making $75,000, $100,000 a year and you choose not to have health insurance and you get pregnant, well, you had an offer to have health insurance and you chose not to access it. I think that is why you are getting some question as to whether or not it is a life-changing event.

Ms. KLIEBERT. Again, we just want a definite answer so that we can move forward on any policy decisions we need to make as a State.

Mr. LANKFORD. And just for quick clarification, they don't pay a fee, they pay a tax.

Ms. SPEIER. Yes.

Mr. LANKFORD. Mr. Connolly.

Mr. CONNOLLY. I thank the chairman. Before my time starts counting, I would ask unanimous consent that the extra one minute and ten seconds provided my good friend and colleague from Georgia be extended to me.

Mr. LANKFORD. No, that was in a response. If you ask a question at the last second, I am going to allow that person to be able to respond.

Mr. CONNOLLY. I thank the chair.

By the way, my friend from Georgia mentioned Newt Gingrich. Senator Hutto, do you happen to recall the reason then Speaker of the House Newt Gingrich opposed the Clinton health care initiative? The single most important reason he objected to the 1993 initiative, do you recall?

Mr. HUTTO. I don't.

Mr. CONNOLLY. It was that it lacked a universal mandate, an individual mandate. Senator Hutto, intellectually, was that a liberal think tank that came up with the idea of an individual mandate?

Mr. HUTTO. It was not, but things have been turned on their head.

Mr. CONNOLLY. It was actually a conservative think tank idea.

Mr. HUTTO. Yes.

Mr. CONNOLLY. Now it is socialism.

Mr. Hudson, you introduced some legislation, H.B. 1193, in 2011, to prohibit a person from being compelled to purchase health insurance, objecting to the individual mandate, is that correct?

Mr. HUDSON. That is correct.

Mr. CONNOLLY. And you just testified to Mr. Bentivolio that, as a realtor, you really believe in disclosure, full disclosure so that a consumer is fully aware of the strengths and pitfalls of a potential purchase.

Mr. HUDSON. That is correct.

Mr. CONNOLLY. When you introduced your bill, did you happen to mention that it was modeled almost identically on something provided by ALEC? Page 12 of that booklet pretty much mirrors your legislation. Were you aware of that?

Mr. HUDSON. If you are referring to something called the Health Care Freedom Act, that was actually sponsored by Representative Plakon. I was a cosponsor.

Mr. CONNOLLY. No, sir. I am referring to a model bill on page 12 of that brochure provided to a conference I think you attended. Did you not attend an ALEC conference where this was discussed?

Mr. HUDSON. I don't have that book in front of me.

Mr. CONNOLLY. So you were not aware of the fact that your legislation happens almost identically to mimic a model bill that ALEC was encouraging State legislators such as yourself to introduce into their respective legislatures? Is that your testimony under oath?

Mr. HUDSON. There are a number of pieces of legislation that are supported by a wide variety of——

Mr. CONNOLLY. Not my question. Were you or were you not using or aware of the ALEC model on page 12, I have it here, that almost identically mirrors the legislation you introduced?

Mr. HUDSON. Yes, sir, that is correct, I was aware of it.

Mr. CONNOLLY. So did you review——

Mr. HUDSON. I would like to finish my question. I was not not civil to you.

Mr. CONNOLLY. This is my time, Mr. Hudson, and I am asking you a question about whether you were aware or not. Your answer, I believe, for the record is you were.

Mr. HUDSON. It is absolutely true.

Mr. CONNOLLY. Did you reveal that to your colleagues? Because you have just said how committed you are as a realtor to full disclosure. Was there full disclosure, when you introduced that bill, that you were modeling it on a national conservative movement funded by the Koch brothers and that this came from their legislative initiative?

Mr. HUDSON. Yes. When we had discussions on this, the term of ALEC did come up.

Mr. CONNOLLY. Thank you.

Mr. Attorney General, you talked about your view about States' rights. South Carolina has a long tradition about that issue. I am just interested in your philosophy of the law. When you lose in a legislative battle and something becomes law, even then you voted against it, and then you lose through the legal system up to the Supreme Court, and the Supreme Court upholds the constitutionality of that law, do you think, as attorney general, it is still okay to try to obstruct its implementation because you just don't agree with it? Is that your legal philosophy?

Mr. WILSON. No, that is not my legal philosophy.

Mr. CONNOLLY. Thank you. So would you take issue with this gentleman, whoever he is, that maybe that is really not a very good legal strategy?

Mr. WILSON. You use obstruct very broadly. My concern is that a law can be constitutional and still be bad policy.

Mr. CONNOLLY. Sure.

Mr. WILSON. And the debate should continue. Now, I believe Obamacare was unconstitutional. The Supreme Court disagreed with me and I have to live with that decision. But that doesn't negate the fact that Obamacare, in my opinion, is still bad policy, and we have a duty as elected representatives to continue to try to improve it as long as it is going to be the law of the land, and that is what we are here to do today.

Mr. CONNOLLY. I couldn't agree with you more if that is what you mean. But obstruction, that word, his, not mine, is a different matter.

Mr. Chairman, I think I have a little extra time, and I yield the balance of it to——

Mr. LANKFORD. Actually, you have none. I was just saying that Mr. Woodall's response was—the witness was responding to his question at the end, and that is the reason it went long. But I have

been very careful on time and have been very fair with everyone on that.

With that, I recognize Mrs. Lummis.

Mrs. LUMMIS. Thank you, Mr. Chairman.

Question for Lieutenant Governor Colyer, Secretary Kliebert, and Representative Hudson: Does Obamacare raise premiums in your State? Does Obamacare raise insurance premiums in your State? Do you know?

Dr. COLYER. We have not had the full release of what it does to premiums across the board for that, and the Federal Government has not released that information for us.

Mrs. LUMMIS. Okay, thank you.

Dr. COLYER. However, we have an example. When we have gone to the website, all of the examples it shows a dramatic increase in cost.

Mrs. LUMMIS. Madam Secretary?

Ms. KLIEBERT. For some groups up to 200 percent. Again, we don't have all the details in terms of what it is going to mean for every different type of population, but we do have data that indicates for some groups it will go up to a 200 percent increase.

Mrs. LUMMIS. Representative?

Mr. HUDSON. Like my colleagues before me, we lack a tremendous amount of actuarial value to be able to make good discerning judgments regarding that, and as the rules have continued to change. We can project, and the projections are not good, they will go up.

Mrs. LUMMIS. Lieutenant Governor, does Obamacare reduce choices in your State?

Dr. COLYER. Absolutely it reduces choices, in the scope of plans that people can choose and also in the number of insurers that are in the exchange.

Mrs. LUMMIS. Madam Secretary, same question.

Ms. KLIEBERT. We currently believe there will be four exchanges. In our Medicaid plans we now have five choices for individuals who have Medicaid recipients. So in those instances, if you compare the two, it will reduce some level of choice.

Mrs. LUMMIS. Representative Hudson, do have an answer to that? Same question.

Mr. HUDSON. Yes, it will definitely reduce choice.

Mrs. LUMMIS. What is the overall view of the citizens of your State with regard to Obamacare? Again, Lieutenant Governor?

Dr. COLYER. Kansans are overwhelmingly against it. They see the economic impact and how it affects their health care.

Mrs. LUMMIS. Madam Secretary?

Ms. KLIEBERT. We have had several polls, as well as debates within the legislature that indicate that overwhelmingly there is not a will to move with expansion or towards some of the implementation of the Affordable Care Act.

Mrs. LUMMIS. Representative Hudson?

Mr. HUDSON. Floridians are absolutely opposed to it, and they recognize in our State, like many States, that the rural areas are going to be disproportionately affected. Lack of choice, lack of access, and tremendous challenges with workforce, which makes

things almost impossible to implement. A one-size-fits-all doesn't work well in clothing; it doesn't work well in this either.

Mrs. LUMMIS. Thank you.

Attorney General Wilson, question for you. Obamacare's implementation has problems: delays and will lead to greater State spending, higher insurance premiums, and greater burdens on business. Can you tell us how the law is impacting the citizens of your State? How are the delays impacting the State's ability to comply with the new Federal requirements as well? So the question is two-fold, the State's ability to comply; individual's impacts.

Mr. WILSON. Well, let me qualify by saying that, independently, that is not something I am qualified to comment on. It is my opinion, my personal opinion that it will adversely affect our citizens and our State. My one thought, Representative, is that I am begging Congress. If they want to criticize the criticizers of Obamacare, if they want to criticize me and other folks who share my view, I welcome that, that is part of our American process.

But look at the questions we are asking as consumer advocates and look at that independent of Obamacare. We have a duty as elected officials to protect the citizens, and I think right now we are getting into a debate on the merits of something that has been decided, instead of how to make it better going forward, and I am begging Congress to look at the questions the AGs have asked. Thank you.

Mrs. LUMMIS. Lieutenant Governor, could you describe the regulation process and how it is impacting Kansans as citizens and the Kansas government as well?

Dr. COLYER. There are some issues of transparency. Here it is two weeks before, we don't know what all of the rates are. We are getting new software updates. We have a new software update coming sometime before October 1st, so even if the Navigators can't be trained, up to date on that. We are having to work overtime to try to comply.

Mrs. LUMMIS. Considering that the President of the United States, after whom the bill is named, is the person who has done the most to delay implementation of Obamacare, do you think it is appropriate to say that the obstruction is coming from outside the White House?

Dr. COLYER. No. I wish they could block a number of other areas as well.

Mrs. LUMMIS. Thank you, Mr. Chairman. I yield back.

Mr. LANKFORD. Thank you.

I recognize the ranking member, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Ms. Sobel, I would like to ask you about the important role that Navigators will play in helping the uninsured sign up for benefits under the Affordable Care Act. By the way, in my district, I just had 400 people Saturday morning to come out, trying to find out more about this. The attorney general, I talked about making government work, they came out because they wanted to take advantage of the law. As a lawyer, I am trained to look at the law, and, as a legislator, to uphold the law.

Ms. Sobel, according to a memorandum released this morning by the Minority staff of Energy and Commerce, Navigator grant recipi-

ents will directly enroll nearly 1.1 million uninsured people in the exchanges and in Medicaid. They also expect to inform an additional 7.3 million people through public education efforts about the benefits of the Affordable Care Act.

Moreover, according to the memorandum, many of these organizations are experienced in precisely the type of outreach necessary to get people enrolled in the exchanges. They have linked families in need with public and private benefits for which they are eligible, such as food stamps, Medicaid, disaster assistance, S–Chip, the Medicare Part D benefit, by the way, which a number of people on this side of the aisle were against, but yet and still, when it became the law, we did everything in our power to make sure our constituents were informed of it, and the low income subsidy for Part D benefit.

Finally, according to the memorandum, there is strong and effective privacy protections in place in the Navigator Program. All grant recipients must abide by laws that prohibit the use or disclosure of personally identifiable information or face stiff criminal and civil penalties. Many of the grantees have adopted additional privacy practices for their staff above and beyond those required by the Federal regulation and have a proven track record of responsibly handling sensitive personal financial and health data in the course of their work.

Ms. Sobel, I think we can agree that implementing the Affordable Care Act is a heavy lift. I am not saying that there aren't any legitimate privacy concerns or that we shouldn't examine the issues of data security and Navigator training. But do you think that Governor Scott's decision to ban Navigators from operating on the grounds of county health departments was a necessary or even a remotely proportionate response?

Ms. SOBEL. Thank you for that very good question. I basically think it is a roadblock; it is a sandbag. He overreacted. There are standards in place from the Affordable Care Act about Navigators, as well as Florida having in place criminal background checks and other standards that the State put forward. I think that this is an effort to stop people from enrolling, and it is just unfair, not right, and it hurts a lot of people who need the information.

Mr. CUMMINGS. I told my constituents on Saturday, I said it is one thing to have opportunity; it is another thing to know about it and then to be able to take advantage of it. Do you believe that this and many of the other onerous regulations that Republican State officials and legislatures across the Country have imposed on Navigators are motivated by desire to delay, hinder, and obstruct enrollment in the exchanges?

Ms. Jackson, could you answer that? Did you hear my question? I said do you believe that this and many of the other onerous regulations by Republican State officials and legislatures across the Country have imposed on Navigators are motivated by desire to delay, hinder, and obstruct enrollment in the exchanges?

By the way, I might add that it just came over the wire that the Republican conference, Speaker Boehner said this morning, talking to the Republicans in Congress, every member in this room is for de-funding Obamacare, while letting the rest of the Government continue to operate.

Ms. JACKSON. I totally agree with what you are saying. As a practicing attorney and a legislator in the State of Louisiana, I have seen so much obstruction of this law. It somewhat reminds me of what I learned in my history lessons about the civil rights structures and the right to vote that was given to minorities. States began to obstruct those, and in Louisiana we have seen just that example with the Federal Affordable Health Care Act, that there has been a major obstruction.

Mr. CUMMINGS. Mr. Chairman, I would just like to enter into the record the staff report from the Commerce Committee.

Mr. LANKFORD. Absolutely. Without objection.

Mr. CUMMINGS. Thank you very much.

Mr. LANKFORD. Mr. Horsford.

Mr. HORSFORD. Thank you, Mr. Chairman. I am going to be quick because I have a number of points.

First, Mr. Attorney General, just so that you know, on Wednesday, September 11th, 2013, the House Committee on Homeland Security Subcommittee on Cybersecurity, Infrastructure, Protection and Security Technologies had a hearing on this very subject around the data hubs, where we are with the implementation. In your testimony you talked about deadlines not being met. Those were on-the-record responses that were provided by the auditor, the OIG who oversees this, and the result was the deadline was met. So while we want to have talking points that say something else, the reality is different.

Mr. Chairman, I attended a brain health trust in my district this last Saturday and one thing that was made clear to me is there is more work to be done on the implementation of the Affordable Care Act; the outreach that is necessary, the education that is necessary, the fact that people need to understand that this is in large part about expanding care under Medicaid and expending benefits under Medicare, and adopting a new marketplace under the exchange.

I want to say our governor, who happens to be a Republican, who was part of the lawsuit with other States that challenged the constitutionality of the Affordable Health Care Act at the time I served in the State legislature, allowed his director of Health and Human Services to continue to work on the implementation of the bill until the outcome of the Supreme Court's determination. And because he made that decision, Nevada is ahead of the mark on the implementation of our marketplace exchanges. They have agreed to expand Medicaid. Our Navigators have been recruited and trained, and are ready to do their job. And this from a Republican governor who did not agree with the law. But he understood his job was to implement the law as it was adopted by Congress and upheld by the Supreme Court.

So in my State I have far too many constituents who will benefit under the Affordable Care Act to not see it implemented. Is it perfect? No. Does this Congress need to do its job to make the necessary adjustments? Yes. And I am glad to hear that Mr. Jordan shares my concern and those concerns of Labor, particularly the AFL–CIO, on a provision of the bill that does need a congressional fix; and I would ask him, even though he is not here, if he will join

me in bringing forward legislation so that we can fix that and other provisions.

Let me ask my couple of questions.

Senator Hutto, what happens to the millions of Americans who now have health coverage if the opponents of the ACA are successful?

Mr. HUTTO. Well, we hope that they are not going to be successful. If they are successful, people could lose coverage that they have now. We hope that won't happen.

Mr. HORSFORD. Representative Jackson, how would it affect your constituents if suddenly they had to worry about insurance companies rescinding their insurance because of preexisting conditions?

Ms. JACKSON. I think we will be in the same boat that we were in a year ago when the governor of our great State asked us to defund hospice care. We would begin to look for solutions that really weren't solutions and our constituency would not be offered any health care at all; and, if offered health care, very minimal, and forced to go into emergency rooms when there are dire need situations in health care.

Mr. HORSFORD. And Senator Sobel, more than 32.5 million seniors have already received one or more free preventative services because of the Affordable Care Act. Can you express to the subcommittees the importance of these services to your constituents?

Ms. SOBEL. Absolutely. And if the bill is repealed, I believe that there would be greater hardships for our seniors. It would be sinful and shameful to repeal any part of the benefits that have already passed.

Mr. HORSFORD. So, Mr. Chairman, you know, I know that there are those on the other side who have differing opinions about where we are with the Affordable Care Act, but after hearing from my constituents, small business owners, those in health care in my State, I believe that it is time for us to stop having these continual efforts to defund the Affordable Care Act and it is time for us as Congress to do our jobs in implementing it and moving forward, and I would use my home State of Nevada as an example of how Republicans and Democrats, the governor, the legislature, and members here in Congress, are working to do our job and not obstructing the Affordable Care Act.

Thank you, Mr. Chairman.

Mr. LANKFORD. Thank you.

I recognize, for just some closing comments, Ranking Member Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you.

First of all, let me say to Attorney General Wilson I too am very grateful for your service to this Country. I was trying to make the point that all of us here have the great luxury of having a Government-sponsored health insurance plan to benefit from. And the hope is that for the 45 million Americans who have no insurance whatsoever, that the Affordable Care Act will place them on equal status with all of us.

Let me also point out there is a script that is being used that isn't accurate, and when people talk about the Affordable Care Act as costing us so much money, that couldn't be further from the truth. In fact, the very nonpartisan Congressional Budget Office

has said that we will save $1.3 trillion over the next two decades with the implementation of the Affordable Care Act. Now, as a Country, we spent 18 percent of our gross domestic product on health care, 18 percent, more than the next 10 biggest spenders in the world, including Japan, Germany, France, China, the U.K., Italy, Canada, Brazil, Spain, Australia combined. And you might think, well, we get better health care, but the fact of the matter is we do not. In fact, we rank 38th in the World Health Organization's ranking of countries in terms of the quality of their health care. We rank number one in spending and 38th in overall health care.

Now, the reference made by my good friend, Mr. Jordan, and by others on the other side of the aisle about the comment made by Max Baucus has been taken out of context and, Senator Hutto, you made reference to it. And I would like to just point out what was really being said by Senator Baucus. There was $554 million requested by the President in his budget for promotion and advertising and education on behalf of the Affordable Care Act.

Our good friends on the other side of the aisle chose to strike that funding completely, and it was with that backdrop that Senator Baucus said that without promotion, without education that there is going to be a train wreck relative to the implementation because people aren't going to know about it. So when we use the term train wreck, let's use it accurately as it reflects Senator Baucus' comment.

With that, I would like to point out, finally, that the hand-wringing that is going on here is all well and good, but the truth of the matter is that starting October 1st there will be six months in which people will have the opportunity to enroll. They will have the opportunity to enroll until March. Lots of these kinks will be worked out during that period of time, and I think that it would be better for all of us to not be the obstructionists that some have suggested.

And I would like to end by quoting Governor Snyder from Michigan, a Republican, who said, and said it very well, it is the law of the land upheld by the U.S. Supreme Court, and it is being implemented. Some believe that fighting it is good politics. I believe that finding a way to make it work for our State is good government.

I yield back.

Mr. CUMMINGS. Would the gentlelady yield for that one minute?

Ms. SPEIER. I certainly will.

Mr. CUMMINGS. Thank you very much.

I just want to thank all of our witnesses for being here today. We may disagree, but the real deal is we are talking about our fellow Americans. We are talking about our brothers, our sisters, our neighbors, and there are people who, and I was just, like I said, in my district this weekend talking to some of my constituents, and there are people who really need this.

I tell the story about when we voted for the Affordable Care Act I got to the Floor of the House four hours early. I sat on the front row and I had only one prayer. I said, God, don't let me die before I vote for it. And the reason why I said that is because I knew it would save lives. I knew that it would affect generations yet un-

born. I knew that it would allow some mother to be able to save her child. I knew it would have a tremendous effect.

We have to make it work. I am tired of people saying it is hard, this is hard. Well, a lot of things are hard. We are America. We are better than that. So I am looking forward to all of you all working with us not about de-funding, not about destroying, but trying to make it better.

With that, I yield back, and thank you, Mr. Chairman.

Mr. LANKFORD. I would thank the witnesses for coming and being a part of this dialogue. This is in your lap in a lot of ways, as far as implementation; you are the one on the phone trying to get answers, writing letters trying to get answers, dealing with the implementation on the ground, and many of you will be on the first line of that phone call, trying to be able to get things resolved.

In my State, they gathered all the State leaders together last week from all the different agencies that have any connection and they had a long list of all the unanswered questions, and they wanted to get everyone together so they could pool it and find out what everyone knew and get all those answers so everyone could share it. What they did instead is they got all the State leaders together, listed the questions, and none of them had the answers. All of them assumed someone else knew this and they just weren't sharing it. None of them knew what is going on.

So, again, the focus of, gosh, this is going to be great is very different when you have to implement and when it is coming at you, and the questions come to you. I would commend to anyone's reading, on this committee and outside this committee, the Navigator report that was done by this committee dealing with the issues of fraud, dealing with the exposure areas that we have that are a real risk to consumers.

We have had a hearing on the data hub to ask some of the questions that should be asked about security because a lot of Americans' information is about to be exposed. But with the Navigators and all that is happening in the days ahead, and as we have seen the reduction of time that is now required in their training and what is there, there are serious issues.

I know the ranking member has mentioned we are 38th in the world in health care. I would say in my district, in Central Oklahoma, we have more advanced cancer care in Oklahoma City than in all of the U.K. We had a hospital open in Oklahoma City that is a straight fee-based hospital, and they were surprised to see that the first thing that happened was the Canadians started coming for health care. Twenty-five percent of their business are people from outside the Country that come to that hospital from all over the world.

And when people are sick and they need advanced care, they are coming here to get that. The term medical tourism didn't exist years ago, but now many of our communities see it as some of the finest hospitals in the world are located right here; and the challenge is do we put that medical advancement at risk by limiting reimbursements, limiting access to that, controlling how it is done in the days ahead so that the medical innovation that is currently occurring slows down and that we suddenly become equal with the rest of the world, rather than leading the rest of the world in med-

ical innovation and device manufacturers and drug developments and such. We have to continue to press on to that.

This is a bill where there are major problems. I have heard over and over again it is the law of the land, we should just leave it. We are not doing that with No Child Left Behind. We see that there are major issues on implementing that law, and we have now reached a time where almost every State is under a waiver. No one here is saying we need to implement all of No Child Left Behind, it is the law of the land, we need to demand every part of that is implemented. Why? Because there are major problems with the law. And we can see it based on how it is implemented, so waivers have gone everywhere to try to free everyone up from what is happening on No Child Left Behind.

We are seeing the same thing occur with the Affordable Care Act; waivers for employers, waiver for certain people, waiver for certain group, because the problems continue to double up on this. Right now the House and the Senate are dealing with what do we do to replace No Child Left Behind because it has become such a problem, and in the days ahead we will finally come to a point of saying there are so many issues and so many problems with the implementation, we have to look again at what do we do to replace this.

I look forward to the day when States are allowed to experiment, as my State now has to come begging to the Federal Government to do things to take care of the needy in my State. There is a program called Insure Oklahoma, which has been a fantastic program to be able to serve people in my State of great need, which we continue to expand. Now we have to beg to allow that program to continue to go forward.

When health care is controlled from Washington, D.C., it is about numbers. When it is controlled in State and local areas, and counties and districts with great need, and I have many rural districts in my State, it is about neighbors and it is about families and real lives. So at the end of this day hopefully we have brought some questions to the table that we can get resolution on and hopefully we can continue to focus on families and lives.

Thank you again for being here and for being a part of this conversation. With this, we are adjourned.

[Whereupon, at 12:48 p.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Statement of Chairman James Lankford
Subcommittee on Energy Policy, Health Care and Entitlements
Committee on Oversight and Government Reform

Federal Implementation of ObamaCare: Concerns of State Governments

September 18, 2013

In the past month, I have personally spoken with a Dad who told me his high school graduate son cannot find a job that will hire him for more than 29 hours a week.

I spoke with a Mom who brought me her late-20-something son's insurance paperwork, which notified him that his health premiums will increase from just over $200 a month to over $800 a month in January.

I talked to a family struggling with their family business because they cannot afford the mandates, but they also cannot sell the business they worked so hard to build.

The high-risk pools hit their max in March of this year, preventing anyone else from entering the high-risk pool.

No one disputes that there were concerns with the U.S. healthcare system that predate Obamacare Chief among those concerns is that the rising cost of health care was crowding out other items in family budgets and contributing to massive federal budget deficits.

Obamacare was designed to fix three problems by reducing the cost of medicine, providing universal coverage for every American and increasing the quality of health care in America.

Americans were told over and over that if they liked their doctor or their insurance, they could keep them.

After decades of work, union members are furious at the changes to health benefits and the traditional 40-hour work week.

While Congress passed the law three years ago, implementation of the law has been mired with one problem after another. According to a report by the Congressional Research Service, the Administration has missed approximately half of Obamacare's required deadlines. A recent GAO report on state progress with exchanges found that "compressed timeframes" and "a lack of clear federal requirements related to the federal data services hub" presented major IT challenges to opening their exchanges for enrollment on October 1, 2013.

Two months ago the Administration delayed Obamacare's employer mandate and several reporting requirements. Although I believe the employer mandate is bad policy, the effect of this unilateral delay by the Administration will be that exchanges will have greater difficulty verifying whether individuals have an offer of coverage at work, thus exposing taxpayer to the risk of significant spending on subsidies for those not qualified to receive them. Moreover, the

Administration only delayed the employer mandate. Individual citizens are still liable for the penalties, but businesses are not liable.

State leaders from across the country have complained that the Administration has not adequately responded to their questions and concerns. Since many states have part-time legislatures that are only in session during the spring, HHS's failure to issue timely guidance harms state ability to implement the law and better protect its citizens from its harmful aspects.

Today, we are pleased to hear the testimony of state officials involved in much of the day-to-day work in preparing their respective states for the start of Obamacare. We have with us today Lieutenant Governor of Kansas Jeff Colyer, M.D., Florida State Representative Matthew Hudson, Secretary of the Department of Health and Hospitals from the State of Louisiana Kathy Kliebert, and Attorney General for the State of South Carolina Alan Wilson.

Yesterday, the Democrats on the Committee threatened not to participate in the hearing unless we invited eight of their selected witnesses. Since normally the Minority only selects one witness and even the Majority only had four witnesses, it seemed like a fairly audacious request. But, we did not want members of a committee tasked with oversight to walk out and fail to hear the serious struggles states are experiencing as a result of the Administration's implementation of ObamaCare, so we made the unprecedented accommodation to let them invite the same number of witnesses as the Majority. Members should not walk away from states struggling to implement Obamacare. We should listen to their concerns and try to find solutions.

One area that will be explored today is the Administration's Navigator and Assister programs. One of the witnesses here today, Attorney General Wilson from South Carolina, along with 12 other Attorneys General, sent a letter to Secretary Sebelius on August 14th asking questions about the Navigator outreach program. As is the pattern, the Administration has not yet responded. In fact, I spoke yesterday with healthcare leaders in my own state, and they informed me that they cannot get answers from HHS. The Navigators they speak to have no idea what is happening, and we are only days away from the October 1 launch date.

Fortunately, the Committee has conducted oversight of the Navigator and Assister program. I would like to introduce into the record a preliminary staff report on our findings related to the Navigator and Assister programs. These findings were largely based on transcribed interviews with top HHS officials and internal HHS documents produced to the Committee.

This report shows that the Navigator and Assister programs are rife with mismanagement and carry the risk that a large number of Americans could fall victim to fraud and identity theft:

- Top HHS officials admitted that the Administration failed to conduct any analysis about whether or not it should require all individuals hired by Navigator and Assister organizations to pass a background check and be fingerprinted.

- The Administration decided to leave the responsibility for authenticating Navigators and Assisters to the organizations receiving the grants to implement the programs. As a

result, the federal government will not be able to provide consumers with a list of individuals officially certified as Navigators and Assisters.

- HHS officials deemed several marketing activities inappropriate, including door-to-door solicitation and direct phone calls but have not taken steps to ban them.

- HHS allows Navigator and Assister organizations to pay their employees based on the number of individuals they enroll, which creates an incentive for those employees to provide biased or incomplete information about ObamaCare to maximize enrollment.

- Individuals employed by Navigator and Assister organizations do not have to disclose that they are paid per enrollee to individuals with whom they interact.

Every program in the federal government needs oversight. That should also apply to the newest program in government, Obamacare. While our nation spends billions, it is reasonable to ask if it is going well and accomplishing what it was designed to do.

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Statement of Chairman Jim Jordan
Subcommittee on Economic Growth, Job Creation and Regulatory Affairs
Committee on Oversight and Government Reform

Federal Implementation of ObamaCare: Concerns of State Governments

September 18, 2013

Three-and-a-half years ago, a Democratic Congress jammed ObamaCare through the Congress without a single Republican vote.

ObamaCare has only grown increasingly unpopular as Americans have learned more about it. In fact, in a new poll, over half of Democrats believe that ObamaCare is going to harm their health care.

I believe ObamaCare should be repealed because it is bad law and bad policy. Here is what we know so far about ObamaCare that has led me to this conclusion.

First, ObamaCare significantly increases the size and power of the Federal Government.

- ObamaCare tasks the IRS with implementing and enforcing at least 47 new provisions, including 18 new taxes. These taxes are expected to raise $1 trillion dollars over the next decade. Just this year, the IRS has requested nearly $500 million to enforce ObamaCare, including 2,000 new full-time employees.

- The Administration's implementation of ObamaCare has already added over 10,000 pages of regulations to the Federal Register.

Second, ObamaCare has harmed the economy and job growth by leading employers to drop coverage and cut the hours of their workers.

- The *Cleveland Plain Dealer* reported that many colleges, universities, and town governments are limiting the hours of part-time workers to under 30 hours to stay under the employer mandate threshold.

- Regal Cinemas, one of the largest movie theatre chains is reducing many workers to less than 30 hours per week because of ObamaCare.

- This Committee has heard testimony from numerous owners over the past two years about how they will be forced to lay off workers because of ObamaCare.

- Leaders of three major unions wrote the President last week demanding significant changes to ObamaCare. They wrote that the Administration's implementation of ObamaCare will "destroy the foundation of the 40-hour work week that is the backbone of the American middle class."

Third, ObamaCare has disrupted Americans' health insurance coverage and reduced choices.

- Kroger, a major supermarket chain, recently announced that it would no longer provide health coverage to spouses of 11,000 employees working in Indiana.

- UPS is dropping coverage for the spouses of 15,000 workers, citing increased costs from ObamaCare.

- The University of Virginia told employees that they would stop offering spousal coverage because of Obamacare.

- Trader Joe's told their part-time employees that they would no longer offer health benefits for part-time workers.

- Howard Dean, writing in the *Wall Street Journal*, criticized ObamaCare's Independent Payment Advisory Board writing: "The IPAB is essentially a health-care rationing body." Moreover Dean argues that "...these kinds of schemes do not control costs. The medical system simply becomes more bureaucratic."

Fourth, ObamaCare's centralized data collection apparatus and poorly planned and managed outreach campaign exposes Americans to significant risks of identity theft and fraud.

- Although open enrollment is two weeks away, the Ohio department of insurance has yet to receive any navigator applications or certify any individuals for this formal outreach effort. This raises concerns that many Navigators will not be adequately trained to conduct outreach.

- Last week, the Minnesota health insurance exchange admitted that an employee mistakenly released confidential information on 2,400 brokers, including Social Security numbers and addresses.

As the Administration has learned, implementing a deeply unpopular law is very difficult.

The witnesses here today are working hard to understand the law and minimize the law's damage on their populations. These witnesses are from the two-thirds of states that opted not to create a health insurance exchange, largely because of inflexible rules and objections to the law's complicated and expensive mandate, regulation, tax, and subsidy scheme.

This work is difficult because of the failure of the Administration to promptly respond to state concerns and questions as well as significant delays in regulation and guidance. I am deeply grateful that they have come to share their stories about their concerns with the Administration's implementation of ObamaCare.

Finally, in an editorial last month, the Chicago Tribune, a paper that endorsed President Obama twice, called to "delay and rewrite this ill-conceived law. Congress need not start from scratch. Lawmakers can build on what all of us have learned from three years of painful trial and error.

Three years of attempting, but failing, to make this clumsy monstrosity work for the American people."

I look forward to hearing the witnesses' perspective on this debate and am grateful that my Democratic colleagues choose not to boycott the hearing. It is important for the Democrats in the Congress to hear about the very real concerns and challenges that states are confronting in implementing this law and not to pretend that they don't exist. Today's hearing is also a reminder that a one-size fits all federal solution to most problems is far less effective than state-based approaches.

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Testimony Stacie Ritter

Why the ACA is important to me

Good morning, Thank you for inviting me here today to share with you why the ACA is so important to me and my family.

My name is Stacie Ritter, I'm a mother of four amazing kids. My oldest are twin girls, diagnosed with myelodysplastic syndrome when they were only four years old. Both girls had stem cell transplants at the Children's Hospital of Philadelphia 10 years ago. At that time, we hit the lifetime cap on insurance, and filed for bankruptcy. We've bounced back from that, but through no fault of their own, my girls will have pre-existing medical conditions for the rest of their lives.

- Thanks to the ACA, they can no longer be discriminated against if I were to lose or change jobs.
- Thanks to the ACA, we no longer worry about reaching lifetime caps on coverage.
- Thanks to the ACA, the girls can remain on my insurance until they are 26 years old, giving them time to finish college and find a job.

Health insurance isn't simple – especially for people who have never had it before, as well as the 129 million Americans who, like my daughters, have pre-existing conditions. That's why the law established "insurance navigators" to help them. It's important that the navigators be allowed to do their jobs so people can get the medical insurance that they have been waiting for!

I live in the 16th congressional district of Pennsylvania represented by Joe Pitts. I'd like him to stop his attacks on the ACA. It is the law, Representative Pitts -- accept it, help implement it, help to improve it. Like many Americans, I'm tired of all the games! We didn't vote for

nonsense! Health care is personal, not political. It's a basic human right. It's time for everyone to work together so every American can get the health care they deserve!

Testimony of Aqualyn Laury

Before the House Committee on Oversight and Government Reform Subcommittees on Economic Growth, Job Creation and Regulatory Affairs and Energy Policy, Health Care and Entitlements

Wednesday, September 18, 2013

Good morning, Chairman Issa, Ranking Member Cummings, and other distinguished Members of the Committee. My name is Aqualyn Laury, and I live in Alexandria, VA. I appreciate the opportunity to be here to share my story. I'm proud to be here today, as a small business owner, a survivor, and an American Heart Association volunteer advocate.

My story begins back on September 28, 1990 during my 4th week as a freshman at Spelman College in Atlanta. I was walking across campus to my morning class when I experienced a sudden moment of confusion and vision irregularity. When I got to class, I tried to ask some classmates a question and finally realized they couldn't understand me because my speech was coming out garbled. Despite this evidence that something was very wrong, I kept going about my business the rest of the day and even took a philosophy exam. When I finally went to the hospital and saw a neurologist, I learned that I had had a stroke that was caused by a tumor in my heart. I ended up having open-heart surgery to remove the tumor, and to replace the heart valve that the tumor destroyed.

During this ordeal my Mom's health insurance covered me. However, since that September day more than 20 years ago, I have been one of the 122 million Americans who has been labeled as having a pre-existing medical condition. I graduated with a Bachelor of Science in Mathematics from Spelman College and later, an M.B.A. from Duke University. Subsequent to both graduations, I joined great companies with equally great insurance plans like a good "pre-existing" should.

In 2005, I decided to leave my job at a large employer to pursue my dream of owning my own business. I knew it would be difficult to find affordable coverage due to my pre-existing condition, but I couldn't help but to seek greater purpose for my life. Fortunately, or at least so I thought at the time, I was able to secure a health plan through my graduate school's alumni program after COBRA ended. However, later that year, I needed emergency gall bladder surgery and suffered complications because of the same genetic blood disorder that caused the tumors previously. At that point, my insurer rescinded my coverage and left me with $50,000 in medical bills during my first year in business. Do you know how hard it is for a sick person to fight this? But I did and I was both thankful yet disheartened that the non-profit hospital that cared for me wrote off substantial portions of the bill that should have been covered by the insurer. If the Affordable Care Act had been in place back then, it would have been against the law for my insurer to drop me from coverage. I'm grateful that I and other Americans no longer have to worry about losing our coverage when we get sick, even though we've been faithfully paying our insurance premiums.

To: Gary Cohen, Director, CCIIO; James Kerr, Acting Deputy Director, CCIIO; Chiquita Brooks-LaSure, Deputy Director, CCIIO
From: Vicki Gottlich, Director, Consumer Support Group
RE: Process for Training, Authentication, Registration and Certification for In-person Assistance
Date: May 28, 2013

Without appropriate IT solutions in place, CMS staff will be required to utilize a manual process to match the results from EIDM (for authentication) and from Medicare Learning Network (MLN) (for training) to ensure that each individual assister (whether Navigator, in-person assistance personnel, or Certified Application Counselors) has completed both elements of the registration/certification process. In developing responses to the questions posed by Aryana Khalid, we have become increasingly concerned about the ability of CMS staff to authenticate, register, and certify everyone who will be involved in the consumer assistance process.

Registration and certification of individuals:

The MLN business owners have indicated that they will be able to provide us with a list of users that have self-selected as a specific type of assister. Optimally this list will include both the users' names as well as their e-mail addresses.

Our SOPs will encourage assisters to use the same e-mail address to go through both the MLN training and EIDM authentication. We are confident that we can also obtain a list of EIDM-authenticated users, although – as currently built – there is no way to distinguish a potential assister that has gone through EIDM from anybody else (issuer staff, CMS staff, etc.) that has gone through EIDM.

With these two sets of data – EIDM-authenticated individuals and MLN-trained assisters – CMS staff would have to manually match assisters (all 3 types) from one data set to the other. Only after a match has been made would CMS be able to fully register/certify an individual.

Given the scope of the different programs – particularly the CAC program – it is possible that this would entail CMS staff attempting to manually match approximately 20,000 individuals over the course of the year.

Designation of CAC organizations:

An organization that wants to serve as Exchange-designated CAC organizations downloads the application posted on the appropriate website (CCIIO or healthcare.gov), completes the application and submits the application to CCIIO.

CIIO manually reviews and processes the application (probably using an excel spreadsheet). This will require that CCIIO maintain and track information for each organization, including a continually updated list of staff and volunteers, and the name(s) and contact information for any points of contact and approving officials for the organization. This will also require that CCIIO maintain and track the applications received, and the processing and outcome of designation applications.

CCCIIO informs organization of its designation organization (via email) and records this on its tracking spreadsheet.

We anticipate thousands of organizations will seek designation.

Help Desk Issues:

Organizations that want to serve as CACs will have questions about the designation process. Individuals who seek registration and certification will also have questions. If we utilize a manual process, CSG staff will also have to provide the Help Desk function to respond to all of the questions from potential users.

Potential IT solution:

We propose leveraging the existing HIOS contract to perform some of these functions. An outline of how the process would work, including potential questions, is attached. We are seeking front office approval before initiating additional work. We have reached out to BOS to determine whether funding would be available for this work.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

September 18, 2013

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Preliminary Findings of Affordable Care Act Navigators Investigation

On August 29, 2013, Chairman Upton and 14 Republican members of the House Committee on Energy and Commerce sent a detailed request for documents and briefings to 51 groups that received grants to serve as Navigators to help the uninsured sign up for benefits under the Affordable Care Act.

The following day, Ranking Member Henry A. Waxman wrote: "there is no legitimate predicate for these letters and no evidence of any malfeasance from any of the organizations. It is an abuse of your oversight authority to launch groundless investigations into civic organizations that are trying to make health reform a success."

The Committee has received grant applications and other information from 42 of the 51 organizations. A review of these applications reveals that there is no basis for the Republican concerns about the Navigator program. It finds that:

- **Navigators will help millions obtain health insurance coverage.** The recipients of the Navigator grant aim to directly enroll over one million uninsured people in the Health Insurance Marketplaces and Medicaid and will reach an additional 7.3 million people through public education efforts.

- **Navigators have extensive experience assisting individuals with federal and state benefit programs.** The role of educating and enrolling individuals for benefits is not a new role for these organizations; most have vast experience helping individuals in targeted communities with Medicaid or other health insurance coverage, food security programs, legal services, and other counseling or assistance programs.

- **Most Navigators are nonprofit, community service providers, and all Navigators are nonpartisan organizations.**

- **Navigator grant recipients have effective privacy protections in place.** All the grant recipients must abide by statutory provisions providing for the privacy and security of personally identifiable information under the Affordable Care Act, and many are taking additional steps to protect individuals' privacy or already have extensive experience handling highly sensitive personal financial and health data information

I. BACKGROUND

On August 29, 2013, Chairman Upton and 14 Republican members of the House Committee on Energy and Commerce sent request letters to 51 groups that received grants to serve as Navigators to help the uninsured sign up for benefits under the Affordable Care Act. The letter demanded that the groups provide "all documents and communications related to your Navigator grant," and asked that they provide briefings and answer many questions on organization budgets and employee training, education, monitoring, review, and supervision.[1]

The following day, Ranking Member Henry A. Waxman wrote: "there is no legitimate predicate for these letters and no evidence of any malfeasance from any of the organizations. It is an abuse of your oversight authority to launch groundless investigations into civic organizations that are trying to make health reform a success."[2] He concluded that the impact of the Republican investigations "is not to enlighten the Committee, but to intimidate and divert resources from the effort to implement the law."[3]

Recent comments by Republican Committee member Rep. Renee Ellmers, who signed the Committee's original letter, appear to confirm Ranking Member Waxman's concern. The *Charlotte News and Observer* reported that "she said she would be pleased if the congressional navigator inquiry stymies the nonprofits planning navigator work. 'If this ended up resulting in a delay, I wouldn't be unhappy about it,' Ellmers said."[4]

One organization that received the letter from the Committee has withdrawn from the program and returned the funding, telling the Committee that it is returning the grant because "emerging State and Federal regulatory scrutiny surrounding the Navigator program requires us to allocate resources which we cannot spare and will distract us from fulfilling our obligations to

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[1] *See, e.g.*, Letter from Chairman Fred Upton et al. to Arizona Association of Community Health Centers (Aug. 29, 2013).

[2] Letter from Ranking Member Henry A. Waxman to Chairman Fred Upton (Aug. 30, 2013).

[3] *Id.*

[4] *NC Groups Working to Implement Health Care Law Targeted by GOP Data Request,* Charlotte News and Observer (Sept. 7, 2013) (online at www.newsobserver.com/2013/09/07/3166895/nc-groups-working-to-implement.html#storylink=cpy).

our clients."[5] The grant to this organization, Cardon Outreach, was to fund outreach activities in Pennsylvania, Ohio, Florida, and Utah.[6]

On September 9, 2013, the Department of Health and Human Services (HHS) responded to the Committee's request. In an effort to "enable the Navigators to focus on training staff to begin to assist uninsured Americans," the Department answered the Committee's questions and provided copies of the Navigator grant applications. The Department produced 42 grant applications from the 51 organizations originally requested by the majority. At the request of Ranking Members Waxman and DeGette, Democratic staff reviewed the Navigator grant applications produced by the Department. This memo provides a summary of the preliminary findings of this review.

II. FINDINGS

A. Navigators Will Help Millions of Americans Obtain Health Care Coverage

According to their application materials, the recipients of the 42 Navigator grants reviewed by the Committee will directly enroll nearly 1.1 million uninsured people in the Health Insurance Marketplaces and Medicaid. They also expect to assist an additional 7.3 million people through public education efforts – such as marketing campaigns, community enrollment and education events, and extensive information, outreach, and referral services – about the benefits of the Affordable Care Act.

In Texas, Navigators will help over 450,000 people sign up for health insurance coverage and will educate over 1.2 million; in Florida, Navigators will help over 330,000 people sign up for health insurance coverage and will educate more than 830,000.

Many of these groups will focus on ensuring that minorities, low–income individuals, individuals with mental illnesses or substance abuse problems, and other vulnerable populations have access to health care coverage under the law. One organization explains that its "primary target clientele are Hispanic field workers and their families."[7] Their programs "reach a variety of ethnicities and communities, but most clients have limited education, many limited English language skills, and are culturally Hispanic."[8] Another organization will target specialized navigation services to "people in recovery from mental illness and/or substance abuse, individuals in active addiction, or those who are seeking behavioral health treatment services."[9]

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[5] Letter from Charles W. Kable, Cardon Outreach, to Members of the Committee on Energy and Commerce (Sept. 13, 2013).

[6] *Citing scrutiny, firm won't aid Pa. on ACA*, Associated Press (Sept. 17, 2013).

[7] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 33 (June 6, 2013).

[8] *Id.*

[9] [Redacted], *[Redacted] has been developed [to] provide specialized navigation services to people in recovery from mental illness and/or substance abuse, individuals in active addition, or seeking treatment*, at 26 (June 7, 2013).

A third organization explains that it traditionally "serves persons who are considered poor or working poor and who are in need of insurance. Some of these populations are single mothers with children, individuals who are victims of crime and domestic violence and urban populations."[10]

B. Navigators Have Extensive Experience Assisting Individuals with Federal and State Benefits

Outreach to these vulnerable communities is not a new role for these organizations. One Navigator grant recipient explains its extensive experience, writing, "[s]ince 2008, our Benefits Access Program has linked families in need with public and private benefits for which they are eligible, especially food stamps, free tax preparation, utilities assistance programs, Medicaid, ... and most recently, disaster assistance in the aftermath of Superstorm Sandy."[11]

Another group states that over the last 12 years, it "has helped more than 80,000 individuals and families enroll in and retain public health insurance including Medicaid, Child Health Plus, and Family Health Plus."[12] Another recipient highlights the work of just one of its nonprofit consortium members, explaining that it has "extensive prior experience assisting low-income individuals with public health insurance, such as Medicaid and CHIP, including applying the regulations to an individual's situation, administrative and judicial appeals, and navigating the bureaucratic process inherent in the administration of public benefit programs."[13]

At least one organization plans to complete the same education and outreach activities for the Affordable Care Act that is undertook during the rollout of the Medicare Part D program. The organization explained in its Navigator grant application that in the past, it served as the lead "in an effort to enroll eligible, low-income populations in the Low Income Subsidy (LIS) and the Medicare Part D benefit."[14] The organization explained:

> Beginning in 2004, this effort encompassed education and outreach efforts for initial efforts into these brand-new federal programs. [The organization] mobilized its network to hold regional enrollment events, conducted telethons, provided mobile enrollment services, fielded telephone inquiries through its hotline, performed eligibility screening, and completed hundreds of applications for the LIS and during open enrollment periods

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[10] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 12 (June 5, 2013).

[11] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 12 (June 6, 2013).

[12] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 43 (June 6, 2013)

[13] [Redacted], *Statewide consortium of navigators to enroll the uninsured into the federally facilitated marketplace*, at 23 (June 6, 2013).

[14] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 34 (June 5, 2013).

for Medicare Part D. This experience demonstrates a long-standing commitment to expanding access to health coverage through public education and outreach.[15]

C. Most Navigators Are Nonprofit Community Service Providers

The grant applications reviewed by the Committee staff reveal that the vast majority of Navigators are nonprofit community service providers, many of whom have extensive experience in assisting low-income people with complex public benefit programs. Forty of the 42 organizations for which the Committee has applications are not-for-profit entities. Thirty-five are nonprofits or nonprofit-led consortia, two are state universities, two are private entities or private entity-led consortia, one is a county government, and one is a municipal corporation.

Republican leaders have raised concerns that the Navigators would use information provided from individuals they help sign up for coverage for "fundraising, voter registration efforts, [or] campaign activities."[16] But all 42 of the organizations whose applications were reviewed by the Committee staff were nonpartisan and nonpolitical in nature.

D. Navigators Have Effective Privacy Protections in Place

Republican attorneys general have written that "we are concerned that [HHS] has failed to adequately protect the privacy of those who will use the assistance programs connected with the new health insurance exchanges."[17] But the Democratic staff review of Navigator grant applications indicates that the recipients have effective privacy protections in place.

All the grant recipients must abide by 45 C.F.R. § 155.260, the statutory provisions providing for the privacy and security of personally identifiable information under the Affordable Care Act. These regulations dictate the manner in which grant recipients can collect, use, and access personally identifiable information. Among other requirements, the law provides that "[p]ersonally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure."[18] Any organization or individual that knowingly or willfully uses or discloses information in violation of these regulations is subject to a civil penalty of $25,000 per individual, per disclosure.[19]

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[15] *Id.*

[16] *See, e.g.*, Letter from Chairman Fred Upton et al. to Arizona Association of Community Health Centers (Aug. 29, 2013).

[17] Letter from State Attorneys General to the Honorable Kathleen Sebelius (Aug. 14, 2013).

[18] 45 C.F.R. § 155.260(a)(3)(vii)

[19] Exchange Establishment Standards And Other Related Standards Under The Affordable Care Act, 45 C.F.R. § 155.260.

In addition to these privacy safeguards, many organizations that received navigator grants are taking additional steps to protect individuals' privacy. At least 15 of the organizations have additional privacy practices for their Navigator staff, including background checks, training in Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, and computer security policies.

Moreover, many of the organizations already have extensive experience handling highly sensitive personal financial and health data information in the course of their work to assist individuals in need of state or federal assistance program. Grant applications reveal that at least 27of the 42 organizations have extensive past experience in handling such information. One organization explained:

> As a HUD-approved housing counseling agency, [the organization] already has extensive data privacy and security standards and protocols in place as a result of our contracts to provide foreclosure prevention counseling. During the mortgage modification application process, clients are required to gather and bring in a variety of official documents that include private and/or confidential information; applications are submitted online, but the paper copies must be kept on file at our location. Application data is submitted online, protocols regarding the use of computers and laptops or tablets are already in accordance with 45 C.F.R. § 155.260. In addition to online data privacy and security policies, we have protocols in place that physically separate client data files in a secured room away from other program areas and offices. We have written procedures for accessing filed client data for appointment and returning it to the client file, (including signature logs identifying the staff who access files) and policies governing the data destruction once the mandatory storage timeframe has expired. Finally, all staff and contractors are required to sign confidentiality agreements covering client information as a condition of employment. These policies and protocols will be used for the Navigator program as well.[20]

[20] [Redacted], *Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges*, at 37 (June 7, 2013).

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August 14, 2013

Via Certified Mail & Email

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Kathleen.Sebelius@hhs.gov

Re: A communication from the States of West Virginia, Alabama, Florida, Georgia, Kansas, Louisiana, Michigan, Montana, Nebraska, North Dakota, Oklahoma, South Carolina, and Texas regarding data privacy risks posed by programs assisting consumers with enrollment in health insurance through the new exchanges

Dear Secretary Sebelius:

As the chief legal officers of our states, we are concerned that the U.S. Department of Health and Human Services ("HHS") has failed to adequately protect the privacy of those who will use the assistance programs connected with the new health insurance exchanges. The Patient Protection and Affordable Care Act provides funding for groups to assist consumers in understanding their health insurance options on the new exchanges. When the exchanges begin enrollment, various "navigator," assister, application counselor, and other consumer outreach programs will begin inputting consumers' private data into insurance applications to help consumers enroll in health insurance plans. We take very seriously the privacy of our states' consumers and believe that your agency's current guidance regarding these groups suffers numerous deficiencies.

A Risk of Inadequate Training

Personnel in many of the new programs will have significant access to consumers' personal information, yet HHS's relevant guidance lacks clarity regarding privacy protection. In the July 17, 2013 Final Rule relating to the Standards for Navigators and Non-Navigator Assistance Personnel, HHS stated that personnel will "receive training on the privacy and security standards applicable" to their work. It promises that the training will be "extensive." But the Rule did not set forth any of the applicable standards beyond citing 45 C.F.R. § 155.260, which merely sets forth broad principles for data protection: "individual access," "correction," "openness and transparency," "individual choice," "collection use and disclosure limitations," "data quality and integrity," "safeguards," and "accountability." As to what these principles mean in practice, the Rule provides platitudes with little concrete guidance, requiring: "reasonable operational, administrative, technical, and physical safeguards to ensure [data] confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure"; protections "against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information"; and "openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information." The Rule does not even require uniform criminal background or fingerprint checks before hiring personnel; indeed, it does not state that *any* prior criminal acts are *per se* disqualifying.

Likewise, in the related June 19, 2013 Proposed Rule on Program Integrity, HHS proposed monitoring grantees for adherence to applicable privacy and security requirements, but did not articulate what those requirements would be. For example, while HHS proposed adopting abstract regulations forbidding unauthorized security "breaches" and "incidents," the proposed regulations did not identify what exactly would constitute such events. Moreover, although HHS proposed requiring grantees and exchanges to have accountability standards and procedures in the event of a breach of private information, the agency suggested nothing specific beyond a requirement that HHS be notified of such breaches.

The short time remaining before exchange enrollment begins will only exacerbate these unclear standards. Enrollment is currently set to begin October 1, 2013, and yet many programs have not received their grants and thus have not started preparations. HHS is scheduled to finish awarding grants to applicants no later than August 15, which will leave participating programs only thirty-two business days to screen, hire, and train thousands of new personnel nationwide. In that window, inexperienced new grantees will have to read these "principles" and guess what they should do, and HHS will not have sufficient time to consult with or audit each program prior to enrollment. Consumer privacy will be catch-as-catch-can in each program. As it now stands, it is inevitable that HHS's vague "standards" will result in improperly screened or

inadequately trained personnel. These individuals will be more prone to misappropriate—accidentally or intentionally—the private data of consumers.

To make matters worse, HHS recently announced that it may cut back on its previously announced and already scant training requirements due to time constraints. As reported in the Wall Street Journal on August 5, 2013: "With time running short before enrollment kicks off Oct. 1, the Obama Administration last week cut back on training requirements for these 'navigators.' Officials were concerned there might not be enough time to do more-extensive training before the health-insurance exchanges open." Previously, the Rule stated that navigators would need up to 30 hours of online training before they start, but, as reported in the same article, HHS has since said in an interview with an official spokesperson that an initial "20 hours would be sufficient." Setting aside the absurdity of simply changing the rules to paper over the Administration's abject failure at implementing the statute, *reduced* training requirements are only going to lead to more problems.

This is exactly the wrong response. HHS must take action to ensure that thorough and specific safeguards are put in place to protect the confidentiality of consumers' data before enrollment begins. Rigorous programmatic safeguards are needed to prevent security breaches by new personnel, as well as to ensure clear lines of accountability for any harm caused by confidentiality breaches. As of right now, your agency has no realistic plan to prevent identity theft or to provide recourse to consumers when it inevitably occurs.

Less Consumer Protection Than In Other Contexts

The risk of inadequate training is only one problem. The proposed consumer safeguards are also woefully substandard. When compared to other privacy protections at the state and federal levels, the vague requirements in your agency's guidance come up well short.

For example, the guidelines appear to provide significantly less protection to consumers with respect to navigators than the states have provided with respect to insurance agents and brokers. For decades, health insurance agents and brokers have been subject to strict state-level exam-based licensing laws and annual continuing education requirements, as well as significant federal and state privacy, security, and market conduct requirements. Furthermore, licensed agents and brokers are personally liable if they fail to comply with these laws and requirements, and are obligated to maintain professional liability insurance to protect consumers. Your guidance does not include comparably rigorous training or educational requirements for navigators. Nor does your guidance impose specific liability for disclosing the many forms of private information that will be given to counselors. Existing laws criminally prohibit sharing certain forms of consumer information, such as tax returns, but those laws do not cover all the information consumers will provide to these HHS-sponsored programs.

What is more, your agency's guidance could be construed to limit state efforts to impose such licensing requirements on the numerous non-profit groups expected to do most of the work of assisting consumers. The Rule provides that state licensure or certification rules must not prevent the application of ACA navigator requirements, and the regulations require at least one navigator entity *not* to be a licensed agent or broker. 45 C.F.R. § 155.210(c)(1); *id.* § 155.210(c)(2) (directing the Exchange to select at least two different types of entities as navigators, one of which must be a community and consumer-focused non-profit group). In practice, non-profit groups are anticipated to take a much greater role, and may be the main source for enrollment assistance. Yet your agency's requirements might bar states from imposing any comparable certification and licensing requirements, such as surety bonds and acts and omissions insurance, on non-profit navigator groups who are not licensed agents or brokers. 78 Fed. Reg. 42831 (stating that the "requirement by a state or an Exchange that Navigators be agents and brokers or obtain errors and omissions coverage would prevent the application of the requirement at § 155.210(c)(2) that at least two types of entities must serve as Navigators, because it would mean that only agents or brokers could be Navigators").

Your guidelines are also less demanding than many federal privacy requirements, such as those applicable to federal census workers and those that the Department of Treasury would like to apply to professional tax preparers. Census Bureau employees take an oath for life to protect identifiable information and information about businesses gathered by the agency. By law, the Census Bureau cannot share respondents' answers with the IRS, FBI, CIA, or any other government agency. The penalty for unlawful disclosure is a fine of up to $250,000 or imprisonment of up to 5 years, or both. Separately, since 2009, the Department of Treasury has aggressively pursued reforms to ensure comprehensive oversight of tax professionals including registration of individual preparers, background checks, certification, competency examinations, and continuing education requirements. Your agency's guidance regarding navigators and other assisters is not remotely comparable.

Finally, the lack of standardized background checks in the Rule pales in comparison to what is usually required for employees in programs receiving federal healthcare funds, particularly with respect to high-risk employees with direct access to consumers. For example, the Centers for Medicare & Medicaid Services has worked with twenty-four states to design comprehensive national background check programs for employees in long-term care facilities with direct patient access. Likewise, in other rules promulgated by your agency, heightened screening, fingerprinting, and background check requirements apply to high-risk providers seeking to participate in Medicare, Medicaid, and the Children's Health Insurance Program. *See* 76 Fed. Reg. 5862.

Further Work Is Required

It is not enough simply to adopt vague policies against fraud. HHS will be giving its stamp of approval to every counselor who interacts with a consumer. This position of trust will allow counselors to gain access to a wide variety of personal information from unsuspecting consumers. Unscrupulous counselors, who are not properly screened out or supervised, will have easy means to commit identity theft on consumers seeking enrollment assistance. According to the Bureau of Justice Statistics, more than five percent of adults already fall victim to identity theft each year, and that is before they hand over all their individual data to a minimally screened and virtually unaccountable "counselor." HHS needs on-the-ground plans to secure consumer information, to follow up on complaints, and to work with law enforcement officials to prosecute bad counselors. Without more protections, this is a privacy disaster waiting to happen.

In the questions below, we have identified a number of areas that we believe are critical to ensuring effective safeguards for the protection of consumers' private data through the navigator, assister, application counselor, or other consumer outreach programs. We ask that you please provide answers to the following questions in writing. Our hope is to work with you to better assess the state of health insurance consumers' data protection and to evaluate the role, if any, for state regulatory action.

1. **Screening Personnel.** Beyond the general grant screening process, does the process for hiring personnel include any screening for staff that may pose risks to consumer data privacy? For example:
    a. Will HHS or others require that all navigators or similar personnel have an educational degree or have any past experience or expertise in the health insurance field or data privacy?
    b. Will HHS or others require uniform criminal background checks or credit reports?
    c. Will certain individuals, such as those who have committed identity theft, be prohibited from becoming a navigator or other program personnel?
2. **Guidance to Program Personnel.** What forms of guidance will HHS provide to program personnel about consumer data privacy protections?
    a. For example, will navigators that receive taxpayer return information be advised of their potential criminal liability, under section 7213(a) of the Internal Revenue Code, for unauthorized disclosure of such information?
    b. Please identify the specific existing laws and standards that HHS believes govern the use of consumers' information and which HHS will expect navigator, assister, application counselor, or other consumer outreach programs to follow.

3. **Monitoring Program Personnel.** How will HHS or others oversee the activities of navigators and non-navigator assistance personnel and ensure that employees do not retain personal information?
4. **Notice to Consumers.** Will consumer outreach programs inform consumers of their data privacy rights and the programs' liability before they decide to receive assistance?
5. **Liability.** Where does liability rest when a consumer outreach program causes harm to a consumer, either purposefully or unintentionally, through the misuse of personal information?
    a. Specifically, does liability rest with the individual who had direct consumer contact, the entity that received funds for consumer outreach, or the exchanges?
    b. Does HHS plan to require that entities that receive federal or exchange-generated funds for consumer outreach activities carry any sort of professional liability insurance?
6. **Fraud Prevention and Remedies.** Does HHS have any plans to provide assistance and relief to defrauded consumers?
    a. Will programs be required to aid consumers who believe information provided to a program has been misused?
    b. How does HHS plan to prevent potential fraud by entities and individuals that may disingenuously represent themselves as navigators or other assisters to unsuspecting consumers?
7. **Penalties.** HHS has promised to take "appropriate action if complaints of fraud and abuse arise."
    a. Beyond civil monetary penalties, what other "appropriate action" will your agency take?
    b. Beyond the False Claims Act, what other existing statutes providing for penalties will apply?
8. **Supplemental State Regulation.** How do you view the role of states with regard to supplementing federal data privacy requirements in all three types of exchanges? Many states have enacted or are considering legislation that further regulates navigators.
    a. Has HHS informed any state that a proposed or adopted state requirement is inconsistent with federal rules? If yes, please provide an exhaustive list of such requirements.
    b. To what extent will states be able to impose additional certification requirements and safeguards relating to a program's data privacy operations, at levels comparable to the licensing of agents and brokers, without being in conflict with the Act?
    c. What is your understanding of the minimum insurance and bonding requirements that states could impose on non-profit programs?

d. How does HHS plan to inform state regulators about which entities and individuals may be performing federally-funded, out-of-state consumer outreach activities in their states, so that they will be aware of who may be interacting with their constituents and may enforce state-based consumer protection requirements?

We appreciate your prompt attention to these critical questions and request a response by August 28, 2013.

Sincerely,

Patrick Morrisey
West Virginia Attorney General

James D. "Buddy" Caldwell
Louisiana Attorney General

Luther Strange
Alabama Attorney General

Bill Schuette
Michigan Attorney General

Pamela Jo Bondi
Florida Attorney General

Tim Fox
Montana Attorney General

Samuel S. Olens
Georgia Attorney General

Jon Bruning
Nebraska Attorney General

Derek Schmidt
Kansas Attorney General

Wayne Stenehjem
North Dakota Attorney General

E. Scott Pruitt
Oklahoma Attorney General

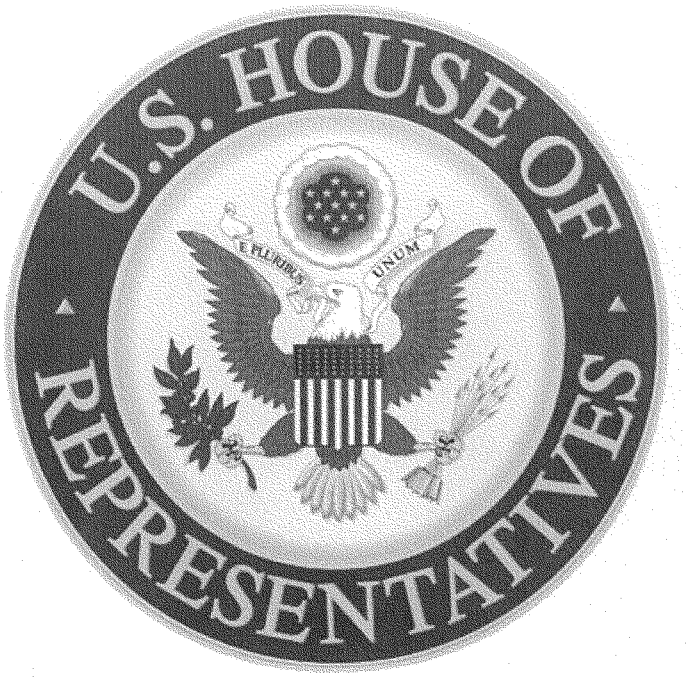
Greg Abbott
Texas Attorney General

Alan Wilson
South Carolina Attorney General

U.S. House of Representatives

Committee on Oversight and Government Reform

Darrell Issa (CA-49), Chairman



Preliminary Staff Report

Risks of Fraud and Misinformation with ObamaCare Outreach Campaign: How Navigator and Assister Program Mismanagement Endangers Consumers

STAFF REPORT
U.S. HOUSE OF REPRESENTATIVES
113th CONGRESS
SEPTEMBER 18, 2013

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Executive Summary

The Patient Protection and Affordable Care Act, also known as ObamaCare, requires states to establish "Navigators" to conduct outreach about the law, provide fair and impartial information to consumers, and facilitate enrollment in new health insurance exchanges and state Medicaid programs. However, ObamaCare explicitly prohibited states from using federal exchange establishment grants to fund Navigator organizations; instead ObamaCare required that Navigators receive funding from a state exchange's operational funds. When several states objected to financing Navigators with state revenue, the Administration created a twin program called In-Person Assisters (Assisters) in states with state-based exchanges, effectively circumventing the statutory restriction on using federal exchange establishment grants to fund the Navigator program. This year alone, the Administration will provide several hundred million dollars of unauthorized taxpayer funds to Assister organizations.

The Administration's improper creation and funding of the Assisters program as a "de facto" Navigator program is just one of many concerns regarding Navigators and Assisters. First, the Administration has failed to create adequate training standards for Navigators and Assisters, even though the Administration assumes most Navigators will lack prior knowledge of ObamaCare or health insurance markets. The training program for Navigators and Assisters states that it will only provide "approximately five to 20 hours of training," down considerably from HHS's previous estimate that it would take 20 to 30 hours to complete the online training. Although individuals employed by Navigator or Assister organizations must pass exams, the exams are conducted online and individuals may attempt the exams an unlimited number of times.

Second, allowing organizations that receive Navigator and Assister funding to pay their employees based on the number of individuals they enroll creates an incentive for those employees to provide biased or incomplete information about ObamaCare to maximize enrollment. Third, despite the statutory requirement that Navigators and Assisters be free of conflicts of interest, the Administration has decided that individuals employed by Navigator and Assister organizations will not have to disclose that they are paid per enrollee to individuals with whom they interact. Fourth, neither Congress nor an independent entity reviewed the training materials for Navigators and Assisters, despite the statutory requirement that Navigators provide "fair and impartial information." Moreover, the incentives that encourage Navigators and Assisters to maximize enrollment raise the risk of massive fraudulent spending on Medicaid and exchange subsidies for individuals who do not meet eligibility requirements.

Although the structure of the Navigator and Assister programs could potentially lead to consumers receiving incomplete and inaccurate information about the law, the main concern for consumers is the heightened risk of identity theft and financial loss from a poorly managed outreach campaign. Navigators and Assisters will come into contact with a plethora of personally identifiable information (PII), including an applicant's Social Security number, date of birth and income, as well as the PII of everyone in an applicant's household. Some of the training received by Navigators and Assisters will be related to consumer protection and privacy standards, but substantial risks remain. In part, substantial risks remain because the Administration decided not to require background checks and fingerprinting of individuals hired

by Navigator and Assister organizations. Under the Administration's plan, unless states have already taken actions to protect their citizens, Navigators and Assisters are not prohibited from hiring convicted felons, including individuals convicted of identity theft or fraud. State efforts to protect citizens from the fraud and identity theft risks posed by Navigators and Assisters have largely been stymied by the Health and Human Service Department's (HHS) delay in releasing regulations and guidance about the Administration's planned outreach campaign for ObamaCare.

In addition to the risks associated with an insufficient training program and the lack of background checks, there are already numerous reports of scam artists posing as Navigators and Assisters to take advantage of people's confusion about ObamaCare. According to recent news reports, scam artists are calling individuals and asking for information to sign them up for their "ObamaCare card," are asking seniors for their personal information to verify their Medicare and Social Security status and are going door-to-door threatening people with prison time if they do not sign up on the spot. The Administration is keenly aware of these reports and concerns, but has thus far failed to take appropriate measures. For example, both Gary Cohen, the Director for the Center for Consumer Information and Insurance Oversight at HHS, and Vicki Gottlich, the HHS official in charge of the day-to-day development of the Navigator and Assister programs until June 2013, testified that direct solicitation was inappropriate, yet the Administration has not clarified which Navigator and Assister marketing practices are allowed and which are prohibited.

The Committee has also learned that senior HHS officials raised concerns about the government's inability to authenticate individuals operating as Navigators and Assisters in May 2013. In response to this concern, HHS considered creating a list of certified Navigators and Assisters for consumers to use as a resource. However, HHS decided against the creation of such a list, and Ms. Gottlich testified that consumers will have no reliable way to learn the identity and association of individuals offering to assist them with enrolling in ObamaCare. The failure of the Administration to provide clarity about prohibited marketing and solicitation techniques and to provide consumers with a list of authenticated Navigators and Assisters substantially increases the number of Americans likely to fail prey to fraud and identity theft.

Findings

The Committee's findings are the result of six months of oversight related to the Administration's Navigator and Assister programs. Most of the findings resulted from transcribed interviews with Vicki Gottlich, who oversaw the Navigator and Assister programs for the federal government until June 2013, and Gary Cohen, the director of CCIIO since August 2012, as well as documents obtained by the Committee.

According to testimony by top Health and Human Services (HHS) Department officials, several states told the Administration that they were unwilling to spend their own resources on the Navigator program established by the federal health law. In response, the Administration created a twin program, called the In-Person Assistance Program (Assisters), which will operate with federal funding in states with state-based exchanges. Top HHS officials acknowledged that Navigators and Assisters will perform essentially the same roles, will undergo the same training, and will be subject to the same federal requirements.

- Internal documents reveal that staff within HHS worried that Assisters would be viewed as "de-facto" Navigators and that there would be much greater spending on the federally-funded Assisters than the state-funded Navigators. For example, the District of Columbia's Exchange will spend $35 million on Assisters, but only $100,000 on Navigators.

The Administration failed to conduct any analysis about whether it should require individuals hired by Navigator and Assister organizations to pass a background check and be fingerprinted.

- During the rulemaking process, top HHS officials expressed concern that the federal government lacked the authority to require that government grantees conduct background checks of prospective employees. However, HHS never conducted analysis about this concern; had they done so, they would have learned that HHS has ample legal authority to put these safeguards in place.

- In a transcribed interview, Gary Cohen, the Director of the Center for Consumer Information and Insurance Oversight within HHS, testified "that requiring background checks and fingerprinting could inhibit the availability of Navigators to provide consumer assistance and to do outreach for the marketplaces" and that there "will be Navigators to serve certain communities which may be unwilling to do that if they had to go through a background check and fingerprinting."[1]

[1] Transcribed Interview of Gary Cohen, U.S. Dep't of Health & Human Serv., in Wash., D.C. (Aug. 7, 2013) [hereinafter COHEN INTERVIEW].

During transcribed interviews, both Mr. Cohen and Vicki Gottlich, the top HHS official engaged in the day-to-day development of the Navigator and Assister programs until June 2013, acknowledged the concern that con artists and identity thieves will pose as Navigators. Ms. Gottlich testified that this problem will only increase as ObamaCare is fully implemented. They also admitted that HHS has not yet provided consumers with a reliable way to verify the identity or authenticity of certified Navigators or Assisters.

- In May 2013, top HHS officials, including Aryana Khalid, Chief of Staff at the Centers for Medicare and Medicaid Services (CMS), expressed concern about the "ability of CMS staff to authenticate, register, and certify everyone who will be involved in the consumer assistance process."[2] The Administration decided to leave the responsibility for authenticating Navigators and Assisters to the organizations receiving grants to implement the programs. As a result, the federal government will not be able to provide consumers with a list of individuals officially certified as Navigators and Assisters.

- Top HHS officials testified that Navigators and Assisters will be allowed to type personally identifiable information into the online application system on behalf of enrollees. One CMS whistleblower warned that because it may not be possible to track every computer and hard drive used by Navigators to gather applicants' personally identifiable information (PII), the sensitive information is vulnerable. The CMS whistleblower also warned that the devices used to scan supporting documents may store and save the images containing sensitive PII.

HHS officials also deemed several marketing activities inappropriate, such as door-to-door solicitation, but have not taken steps to ban them.

- Mr. Cohen and Ms. Gottlich both testified that it would be inappropriate for Navigators and Assisters to engage in activities such as door-to-door solicitation or direct phone calls, or giving gifts of more than nominal value to entice enrollment. However, the Administration has not yet informed the Committee or the American people about any measures it has taken to prevent inappropriate marketing practices.

Ms. Gottlich testified that there is a potential conflict of interest for Navigators and Assisters who are paid based on the number of persons they enroll for coverage through ObamaCare, a payment structure that several states allow.

- Mr. Cohen testified that he believed HHS prevented Navigators in federal exchanges from paying their employees based on enrollment numbers, but that this same requirement was not placed on Assisters in state-based exchanges.

The Administration expects that individuals applying to be Navigators and Assisters will lack any experience related to health insurance and ObamaCare. Despite this expected lack of experience, Mr. Cohen testified that it would be "logical" for Navigators and Assisters to conduct outreach activities *prior* to completing the training.

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[2] Memo from Vicki Gottlich to Gary Cohen, May 28, 2013 (on file with Committee).

I. Introduction

The Patient Protection and Affordable Care Act (PPACA), the legislation commonly known as ObamaCare, directed states to establish health insurance exchanges,[3] government-run entities that facilitate the buying and selling of health insurance. ObamaCare authorized the Secretary of the Department of Health and Human Services (HHS) to set up exchanges in states that declined to establish their own exchange.[4] ObamaCare also requires that newly established health insurance exchanges establish a "Navigator" program to provide unbiased information about ObamaCare, conduct outreach about ObamaCare, and facilitate enrollment in the new exchanges. The law requires that states fund Navigator grants from the states' exchange operational funds and not with direct federal funds.

The Administration was confronted with several unforeseen problems related to its outreach campaign. Most states refused to create exchanges and those that did create exchanges refused to spend state funds on ObamaCare outreach and education. Responding to several states' decisions not to fund their Navigator programs from state revenue, HHS created the In-Person Assistance (Assisters) program, a twin program to the Navigators. HHS then funded Assisters with federal funds. As a result, states that set up their own exchanges will have both a very limited Navigator program (funded from state operational exchange budgets) and an Assister program (funded with federal grants). States that did not set up their own exchange but instead have a federal exchange will likely have only Navigators (funded by HHS through the law's Prevention and Public Health Fund).[5] In addition to using Navigators and Assisters to provide information about ObamaCare and to facilitate enrollment, the Administration is also using Certified Application Counselors, who will largely work out of hospitals or community health clinics, to increase enrollment in ObamaCare.

HHS officials testified that most individuals hired by Navigator and Assister organizations will have no health care or insurance experience. Despite this lack of knowledge, the required training, which includes education about ObamaCare, health insurance, and privacy protection, will only take five to 20 hours to complete and will give trainees the ability to take the online exams as many times as necessary to pass.

Individual Navigators and Assisters will have access to many applicants' personally identifiable information (PII), including Social Security numbers, dates of birth, home addresses, email addresses, and in many cases the PII for other members of the applicant's household. Such information may also be stored on computers and scanners owned by Navigator and Assister organizations. Furthermore, unlike agents and brokers, Navigators and Assisters bear no personal liability if they give taxpayers misinformation that damages their financial interests. Finally, there are already reports from across the country that scam artists are attempting to impersonate Navigators and Assisters to steal credit card information and PII in order to take advantage of massive confusion about ObamaCare.

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[3] Pub. L. No. 111-148, Sec. 1311.

[4] *Id.*, Sec. 1321. Exchanges established by the Secretary of Health and Human Services are referred to as federally-facilitated exchanges.

[5] Abby Goodnough, *$67 Million Awarded to Groups Helping With Health Law*, N.Y. TIMES (Aug. 15, 2013), http://www.nytimes.com/2013/08/16/us/politics/67-million-awarded-to-groups-helping-with-health-law.html.

The potential for the accidental release of thousands or hundreds of thousands of PII is staggering. For example, on September 13, 2013, the *Associated Press* reported that a confidential list, containing names, addresses, Social Security numbers, and other PII of roughly 2,400 brokers, was accidentally released by an employee at MNsure, the Minnesota exchange.[6] In addition to worries about identity theft and fraud, if Navigators and Assisters give inappropriate advice or forms are filled out incorrectly, applicants may receive subsidies for health insurance or Medicaid coverage for which they are not eligible. This will either result in individuals having to pay back those subsidies years later or the federal government spending billions of tax dollars which it cannot recover.

II. HHS's Extralegal Expansion of Navigator Program

To assist states in building health insurance exchanges, ObamaCare gave authority to the Secretary of HHS to make grants to states that created their own exchange.[7] To date, HHS has provided states with over $3.8 billion in exchange establishment grants.[8] The exchange establishment grants can be used for states to develop any of the exchange functions with one important exception: they cannot be used to fund Navigator organizations. According to PPACA:

> Grants under this subsection [that establishes the Navigator program] shall be made from the operational funds of the Exchange and not Federal funds received by the state to establish the Exchange.[9]

When drafting ObamaCare, Democratic leaders in both the House and Senate were conscious about keeping the Congressional Budget Office's estimate of the cost of the legislation as low as possible.[10] This was likely why Congress prohibited Navigator organizations from receiving federal establishment funds.[11]

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[6] *Worker for Minnesota ObamaCare 'exchange' releases private info in security breach*, THE ASSOCIATED PRESS (Sept. 13, 2013), *available at* http://www.foxnews.com/politics/2013/09/13/worker-for-minnesota-ObamaCare-exchange-releases-private-info-in-security/.

[7] The Secretary determines the amount of grants available to states for exchanges. *See* Pub. L. No. 111-148, Sec. 1311 (a)(2) ("[f]or each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.").

[8] Kaiser Family Foundation, *Total Health Insurance Exchange Grants*, STATE HEALTH FACTS (July 10, 2013), http://kff.org/health-reform/state-indicator/total-exchange-grants/.

[9] Pub. L. No. 111-148, Sec. 1311 (i)(6).

[10] President Obama, in a speech to Congress, set a goal for the health care bill to cost $900 billion dollars over ten years. *See* Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009), http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care ("Now, add it all up, and the plan I'm proposing will cost around $900 billion over 10 years....The plan will not add to our deficit. The middle class will realize greater security, not higher taxes."). Liberal columnist Ezra Klein criticized Congress's use of this $900 billion dollar figure as a cap arguing that it makes tradeoffs necessary for the bill to stay under the cap. *See* Ezra Klein, *The $900 billion mistake*, WASHINGTON POST (Nov. 11, 2009), http://voices.washingtonpost.com/ezra-klein/2009/11/the_900_billion_mistake.html ("there's little budgetary flexibility *even if you could find the revenue*, because each dollar is in a zero-sum competition with each other dollar so the entire plan comes in under the limit.").

[11] The Congressional Budget Office originally estimated exchange start-up costs to cost $2 billion between 2010-2019. To date, HHS has spent $3.8 billion creating exchanges, nearly double the original amount, with only 16

At a briefing with Committee staff on April 18, 2013, Vicki Gottlich, Director of the Consumer Support Group at the Center for Consumer Information and Insurance Oversight (CCIIO) and then-head Administrator for the Navigator and Assister programs, confirmed that Navigators and Assisters will perform the same duties, with the only difference being their funding sources.[12] At the time, Ms. Gottlich admitted to Committee staff that ObamaCare did not authorize the Assisters program and that it was a creation of the rule-making process.[13] Therefore, while Navigators are statutorily required in both federal and state exchanges, the Assister program is a creation of HHS that has no statutory backing.[14]

In their transcribed interviews, both Mr. Cohen and Ms. Gottlich admitted that Navigators and Assisters will perform essentially the same role.[15] Because Assisters are funded with federal establishment grants, they replace Navigators in state exchanges and are an end-around of the statutory requirement that Navigators receive funding through an exchange's operational funds and not from federal funds. Emails obtained by the Committee show concern within CCIIO that Assisters would be viewed as "de-facto Navigators."[16] Brian Schwartz, a CCIIO employee, wrote to Ms. Gottlich on December 14, 2012:

> We are wondering to what financial ratio we should [be] holding SBEs [state-based exchanges], so that the IPA [in-person assistance] program is not seen as de-facto Navigator. A few states are requesting a good deal of money for their IPAs, but planning to fund Navigators at a much lower amount.[17]

At a hearing before the Committee on May 21, 2013, Gary Cohen, Director of CCIIO, testified that the Assister program was created because states had expressed concerns about being able to establish Navigator programs without federal funds.[18] During his transcribed

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states and the District of Columbia creating exchanges. One of the contributing factors for the greater spending is likely be the inclusion of funds for assisters. *See* Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, on the direct spending and revenue effects of an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010, Table 2 (Mar. 20, 2010); Kaiser Family Foundation, *Total Health Insurance Exchange Grants*, STATE HEALTH FACTS (July 10, 2013), http://kff.org/health-reform/state-indicator/total-exchange-grants/.

[12] Oversight & Government Reform Briefing by HHS Officials on Navigators and Assisters Programs (Apr. 18, 2013) [hereinafter BRIEFING].

[13] *Id.*

[14] Pub. L. No. 111-148. Sec. 1311.

[15] *Examining The Concerns About the ObamaCare Outreach Campaign, Hearing Before the H. Comm. on Oversight and Government Reform, Subcomm. on Energy Policy, Health Care, and Entitlements, and Subcomm. on Economic Growth, Job Creation and Regulatory Affairs*, 113th Cong. 20-21 (2013) (Statement of Gary Cohen, Director, Center for Consumer Information and Insurance Oversight) ("Mr. Lankford:.... 'What is the difference between a navigator and an assister?' Mr. Cohen.: 'The functions are essentially the same.'"); Transcribed Interview of Vicki Gottlich, U.S. Dept. of Health & Human Serv., at 68 (July 25, 2013) ("Staff: 'Can you describe for us what some of those differences are?' Gottlich: 'They're pretty much the same.'")

[16] Email from Brian Schwartz, to Vicki Gottlich, Director, Consumer Support Group, CCIIO, IPA vs. Navigator funding in an SBE (Dec. 14, 2012).

[17] *Id.*

[18] *Examining the Concerns About the ObamaCare Outreach Campaign, Hearing Before the H. Comm. on Oversight and Government Reform, Subcomm. on Energy Policy, Health Care, and Entitlements, and Subcomm. on Economic*

interview, Mr. Cohen testified that he was aware of the concern that the Assister program would be seen as a de facto Navigator.[19] According to Mr. Cohen, "We understood that the use of 1311 [the section of PPACA that authorizes and funds state exchanges] grant money for In-Person Assisters in state-based marketplaces could not replace the Navigator program. They still had to have a Navigator Program, and they had to be distinct."[20] Mr. Cohen further explained that many states informed HHS that they did not have state funds to spend on their Navigator programs,[21] an indication that states did not value the role of Navigators or Assisters as long as state general revenue was needed for the funding. Since HHS was offering to use federal funds, however, states did not have to devote resources to the outreach effort.

California and New York plan to spend $58 million and $27 million of federal funds on their exchange outreach programs, respectively.[22] Vermont, a much smaller state, plans to spend roughly $2 million.[23] Top officials from the DC Exchange have outlined plans to spend $35 million on Assisters, but only $100,000 on Navigators.[24] While it is difficult to determine the actual breakdown in spending across state Navigator and Assister programs, states with state-based exchanges are not going to spend significant state funds on Navigators when they have access to a huge amount of federal funding for Assisters, who will perform an identical function. Neither Mr. Cohen nor Ms. Gottlich had any idea how much would be spent on Navigators and Assisters in states with state-based exchanges or how states would ensure that Navigators and Assisters are distinct.[25]

Despite a clear prohibition on using federal exchange establishment grants for the nearly identical Navigator program, Mr. Cohen stated that "[t]he statutory authority [for using exchange establishment grants to fund Assisters] is the requirement in the Affordable Care Act that state-based exchanges and all exchanges provide outreach and education and enrollment assistance to people."[26] Mr. Cohen's answer was inconsistent with the information provided by Ms. Gottlich at an April 2013 briefing when she told Committee staff that the authority for Assisters came entirely through the rulemaking process.[27] Furthermore, Mr. Cohen's response was not accurate. Section 1311 of PPACA lists several requirements for exchanges, including maintaining a website, a call center, and utilizing a single-streamlined application.[28] Outside the requirements placed on Navigators, there is no broad requirement in the statute to provide outreach and

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Growth, Job Creation and Regulatory Affairs, 113th Cong. 20-21 (2013) (Statement of Gary Cohen, Director, Center for Consumer Information and Insurance Oversight).

[19] *See* COHEN INTERVIEW, *supra* note 1.

[20] *Id.* at 104.

[21] *Id.* at 105.

[22] Tricia Brooks, *Assister Types Abound: But Will Navigators and Assisters Be Plentiful Enough?* GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE BLOG (May 17, 2013), http://ccf.georgetown.edu/all/assister-types-abound-but-will-navigators-and-assisters-be-plentiful-enough/.

[23] *Id.*

[24] Oversight & Govt. Reform Briefing by DC Exchange Officials (Aug. 26, 2013).

[25] *See* COHEN INTERVIEW, *supra* note 1; Transcribed Interview of Vicki Gottlich, U.S. Dep't of Health & Human Serv., in Wash., D.C. (July 25, 2013).

[26] *See* COHEN INTERVIEW, *supra* note 1.

[27] *See* BRIEFING, *supra* 12.

[28] Pub. L. No 111-148, Sec. 1311(d).

education.[29] At a transcribed interview with Committee staff, Mr. Cohen backed off from the answer he provided at the hearing, stating that his answer "was not as precise as it might have been."[30] According to Mr. Cohen:

> I think the statutory authority comes from, as I said, from 1321(a), which gives the Secretary broad discretion to issue regulations and standards for implementation of the law and, in particular, establishment of exchanges. You know, pursuant to that authority, we have required exchanges to do consumer assistance and to provide outreach.[31]

Despite Cohen's explanation, Section 1311(i)(6) of PPACA clearly prohibits the use of federal exchange establishment grants to fund a state's Navigator program. When Congress inserts specific words into a statute's text, those words are there for a reason. In this case, Congress explicitly stated that federal establishment funds *shall not* be used to fund Navigators. Section 1321(a) of PPACA gives the Secretary authority to issue regulations in order to implement exchanges; however, it does not give the Secretary authority to ignore the statute's plain text.[32] When HHS decided to provide Navigator funds in state exchanges by creating a new program identical to the Navigator program in everything but name, HHS deprived the funding restriction found in Section 1311(i) of its plain meaning and circumvented the law.

HHS's policy permitting states to then fund these de-facto Navigators from federal establishment grants rather than the exchange's operational funds is not supported by the statute and thus spends substantial sums of unauthorized money on ObamaCare outreach. Because exchange establishment grants are essentially unlimited, HHS's decision to provide establishment grants to fund Assisters will result in unauthorized federal spending of hundreds of millions of dollars this year alone.[33]

III. Insufficient HHS-Imposed Navigator and Assister Requirements

One of the Committee's primary concerns with the Administration's proposed rule for the Navigator and Assister program was the lack of standards for the individuals chosen to serve as Navigators and Assisters, including the Administration's decision not to require background checks for individuals applying to be Navigators and Assisters. During the April 18, 2013, briefing, Committee staff asked Ms. Gottlich whether convicted felons, including individuals convicted of identity theft, or someone without a high school degree could become Navigators and Assisters.[34] Ms. Gottlich replied that the proposed rule would permit all of these individuals to work as Navigators and Assisters, but Gottlich as well as several other CCIIO employees in

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[29] *Id.*, Sec. 1311(d)(4)(K). This provision requires exchanges to "establish the Navigator program described in [Sec. 1311] subsection (i)."
[30] *See* COHEN INTERVIEW, *supra* note 1.
[31] *Id.* at 104.
[32] Pub. L. No 111-148, Sec. 1321(a).
[33] Pub. L. No 111-148, Sec. 1311Sec. 131 (a).
[34] *See* BRIEFING, *supra* 12.

attendance encouraged the Committee to submit comments so problems with the proposed rule could be remedied.[35]

On May 6, 2013, Chairman Darrell Issa, Energy Policy, Health Care, and Entitlements Subcommittee Chairman James Lankford, and Economic Growth, Job Creation, and Regulatory Affairs Subcommittee Chairman Jim Jordan wrote to Secretary Sebelius with a number of detailed recommendations to improve the proposed rule,[36] including the recommendation that Navigators and Assisters "be held to the same hiring standard as U.S. Census and IRS employees, who are subjected to FBI background checks during the application process and fingerprinting once hired."[37] The Committee also submitted this letter to HHS during the formal notice and comment period for the rule. On July 17, 2013, the Administration released its final rule on Navigators and Assisters, without adopting any of the common sense recommendations made by these senior members of the Committee.[38] For example, the Administration's final rule does not prohibit Navigators and Assister organizations from hiring individuals convicted of a felony, including those convicted of identity theft, from engaging in consumer outreach activities and potentially accessing hundreds, if not thousands, of individuals' sensitive information.[39] Moreover, the final rule does not require that Navigators and Assisters have graduated from high school or earned an equivalent degree.[40]

During her transcribed interview, Ms. Gottlich testified that "there's nothing that prohibited HHS from [requiring individuals to have gone through a background check]," but HHS "determined that it would be up to the individual grantee to comply with state requirements for background checks and investigations of their employees."[41] According to Ms. Gottlich, "in many states, there would be sufficient checks," "the cost [of background checks] might be prohibitive for some entities," and entities in rural areas might have difficulty with background checks and fingerprinting.[42] Although unsure of the cost of a background check, Ms. Gottlich stated that she "saw one estimate [from the budget of a Navigator applicant] of about a hundred dollars per person."[43] Ms. Gottlich also testified that HHS did not discuss requiring background checks prior to the proposed rule and the issue being raised by Committee staff in April 2013 and that HHS never considered banning convicted felons or individuals convicted of identity theft from being Navigators or Assisters.[44] According to Ms. Gottlich, all hiring decisions are "going to be up to each individual [Navigator award] grantee,"[45] and, if the state law allows, Navigator and Assister organizations can hire convicted felons including those individuals convicted of identity theft.[46]

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[35] *Id.*
[36] Letter from Hon. Darrell Issa, Chairman, Committee on Oversight & Govt. Reform to Kathleen Sebelius, Secretary, Dept. of Health & Human Serv. (May 6, 2013).
[37] *Id.*
[38] 78 Fed. Reg. 42823 (July 17, 2013), *available at* http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf.
[39] *Id.*
[40] *Id.*
[41] *See* GOTTLICH INTERVIEW, *supra* note 25.
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*

During his transcribed interview, Mr. Cohen confirmed Gottlich's admission that CMS failed to conduct **any** real analysis about whether to require that all individuals hired by Navigators and Assisters pass a background check and be fingerprinted.[47] Mr. Cohen described one informal meeting with other HHS officials[48] regarding whether to require background checks for Navigators and Assisters.[49] Mr. Cohen recalled three reasons why the Administration decided against requiring background checks:

> One was cost. One was it wasn't clear to us that [CMS] had the authority or would even be allowed, or able, I should say, is a better word for it, to access the criminal justice databases that would be necessary to perform background checks if what you were looking for was a criminal history.
>
> ....
>
> We had a conversation, and it was expressed in the meeting from [Leon Rodriquez, head of the Office of Civil Rights within HHS], who purported to have some knowledge of this type of issue, that it wasn't clear that we would be able to get access to the criminal history databases that would be needed for the purposes of this type of program. That's what was expressed. I can't tell you whether they're right or not; I'm just telling you what was talked about.[50]

No one bothered to look into whether Leon Rodriquez was right, and no one at CMS apparently considered that CMS could have required Navigator and Assister entities to conduct background checks before hiring, as a condition of receiving the grant.[51] Mr. Cohen also stated that Mr. Rodriquez raised the issue of cost, but he could not recall any specific cost amount.[52] Finally, Mr. Cohen discussed one additional reason that the group considered:

> Q: Were there any separate meetings dealing with the other concerns raised in the Chairman's letter?
>
> A: Not that I recall specifically, no. And I should just say, we were going through the reasons why -- the downsides, if you will, to requiring background checks and fingerprints. There was a third one that I didn't quite get to, which is that, at various times when, you know -- and I think in this meeting, but certainly it has been discussed in meetings that I have been in -- that requiring background checks and fingerprinting could inhibit the availability of Navigators to provide consumer assistance and to do outreach for the marketplaces.

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[47] *See* COHEN INTERVIEW, *supra* note 1.
[48] According to Cohen, the meeting was between himself, Mike Hash, Director, Office of Health Reform at HHS, Chiquita Brooks-LaSure, Deputy Center and Policy Director at CCIIO, Ken Choe, Deputy General Counsel, Office of General Counsel at HHS, and Leon Rodriquez, Director, Office for Civil Rights at HHS, Cohen also mentioned that Christian Young, who works for Mr. Hash, might also have been in the meeting.
[49] *See* COHEN INTERVIEW, *supra* 1.
[50] *Id.*
[51] Section 74.4 Deviations *available at* http://www.hhs.gov/opa/grants-and-funding/grant-forms-and-references/45-cfr-74.html#74.11.
[52] *See* COHEN INTERVIEW, *supra* 1.

Q: How so?

A: What has been expressed is that we are hoping that there will be Navigators to serve certain communities which may be unwilling to do that if they had to go through a background check and fingerprinting. That was the concern that was expressed.[53]

While Mr. Cohen could not specifically recall who initiated the discussion that individuals who HHS was hoping would serve as Navigators might be unwilling to submit to background checks, this point has also been raised by Carla Saporta, health policy director at a nonprofit group in California. According to Ms. Saporta, "[b]ackground checks would create barriers for a lot of communities of color and disproportionately exclude African American and Latino men from participating."[54] Mr. Cohen told Committee staff that the Administration never considered whether to prohibit convicted felons or individuals convicted of identity theft from becoming Navigators and Assisters because doing so was "tie[d] to the background check and the fingerprint."[55]

Both Ms. Gottlich and Mr. Cohen testified that during the rulemaking process they discussed that HHS might not have the authority to require Navigator and Assister organizations to conduct background checks of individuals applying to work as Navigators and Assisters.[56] However, had they looked into whether HHS had this authority, they would have found that they did.[57] Moreover, on July 4, 2013, the *New York Times* reported that Serco, a United Kingdom-based government contractor, obtained a contract with the federal government to process ObamaCare's paper applications for individuals in states with federal exchanges.[58] The contract required that all Serco employees processing paper applications be fingerprinted and receive a background check.[59] Apparently, in this case, HHS's concerns about protecting sensitive consumer information outweighed concerns about the cost of the background checks. In totality, the information gathered by the Committee shows that the Administration never seriously considered requiring background checks for Navigators and Assisters or prohibiting individuals with serious criminal backgrounds from obtaining access to sensitive consumer information.

The Committee has obtained an internal memorandum from May 28, 2013, detailing serious concerns of the Centers for Medicare and Medicaid Services (CMS) about the ObamaCare consumer outreach program. The memo, written by Ms. Gottlich to Mr. Cohen, states:

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[53] *Id.*

[54] Chad Terhune, *Call for screening of healthcare enrollers meets resistance*, (March 15, 2013), available at http://articles.latimes.com/2013/mar/15/business/la-fi-insure-criminal-checks-20130315.

[55] *See* COHEN INTERVIEW, *supra* 1.

[56] *See* COHEN INTERVIEW, *supra* 1; *See* GOTTLICH INTERVIEW, *supra* 25.

[57] Section 74.4 Deviations at http://www.hhs.gov/opa/grants-and-funding/grant-forms-and-references/45-cfr-74.html#74.11.

[58] Robert Pear, *British Company Is Awarded Contract to Administer Health Rollout*, N.Y. TIMES (July 4, 2013), http://www.nytimes.com/2013/07/05/health/british-company-is-awarded-contract-to-administer-health-rollout.html; Sarah Kliff, *Meet Serco, the private firm getting $1.2 billion to process your ObamaCare application*, WASHINGTON POST, July 16, 2013, *available at* http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/16/meet-serco-the-private-firm-getting-1-2-billion-to-process-your-ObamaCare-application/.

[59] Oversight & Government Reform Staff Meeting with Serco Officials regarding HHS Contract (Aug. 14, 2013).

> Without appropriate IT solutions in place, CMS staff will be required to utilize a manual process to match the results … for authentication and … for training … to ensure that each individual assister (whether Navigator, in-person assistance personnel, or Certified Application Counselors) has completed both elements of the registration/certification process…. [W]e are becoming increasingly concerned about the ability of CMS staff to authenticate, register, and certify everyone who will be involved in the consumer-assistance process.[60]

The memorandum was written, in part, because of concerns raised by Aryana Khalid, CMS Administrator Marilyn Tavenner's Chief of Staff, about the outreach programs. Mr. Cohen was able to provide some background information on the memorandum, testifying:

> I was involved in a number of conversations with different people on a general topic of whether we at CMS were going to be able to capture, store, and possibly provide to people the identifying information of each individual person [providing outreach and consumer assistance] … [so] we could provide that information if requested…. So those are the concerns. The concerns were can we keep track of who all these people are, and can we provide that information if we are asked for it.[61]

Mr. Cohen concluded that "ultimately, we decided to put that responsibility on the organization"[62] and that an individual seeking to find whether someone is an authenticated Navigator or Assister should "go to the organization, rather than to us."[63]

Leaving the Navigator and Assister entities to authenticate, register, and certify the individuals they hire does not resolve the concerns raised by Ms. Khalid as discussed in the memorandum above.[64] In fact, CMS's refusal to coordinate the registration of Navigator and Assister personnel or maintain a list of the names of certified Navigators and Assisters exposes consumers to significant risks, particularly given the widespread reports of scam artists and fraudsters who plan to take advantage of Americans' confusion about ObamaCare. As will be discussed in the next section, consumers will be unable to verify if a person offering to provide them information about ObamaCare is working for a legitimate organization. Without a way to verify that a Navigator's affiliation is legitimate, scam artists can easily prey upon unsuspecting enrollees by impersonating a Navigator or Assister.

HHS's decision to outsource the authentication, registration, and certification to the Navigator and Assister organization is also problematic due to the Department's weak oversight plan for the outreach campaign. HHS plans to oversee Navigators the same way that other grants are handled, with quarterly reports from grant organizations overviewed by one program manager responsible for multiple grant awards.[65] HHS's role in overseeing Assister

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[60] Memo from Vicki Gottlich to Gary Cohen, May 28, 2013 (on file with Committee).
[61] *See* COHEN INTERVIEW, *supra* note 1.
[62] *Id.*
[63] *Id.*
[64] *See* COHEN INTERVIEW, *supra* note 1.
[65] *See* BRIEFING, *supra* 12.

organizations is unclear given that the states operating state-based exchanges will be selecting the organization to receive funding. It is unclear how individuals employed by Navigators and Assisters will be held accountable for mistakes or misinformation.[66]

IV. Fraud and Abuse Risks of Navigator and Assister Program

Although open enrollment doesn't start until October 1, 2013, many news outlets have already reported about scam artist attempts to exploit the mass confusion related to ObamaCare. For example, individuals claiming to be associated with the federal government have stolen credit card information and Social Security numbers, and have tricked people into paying for an "ObamaCare card".[67] A *Washington Post* article from September 10, 2013, titled "Using ObamaCare as bait, scam artists target consumers and business owners" describes scam artists targeting consumers through email, phone calls, door-to-door canvassing and fraudulent websites.[68] According to the *Washington Post*:

> In Maryland, scam artists have started calling residents claiming they need to verify Medicare ID and Social Security numbers for purposes associated with the health law… In New York and Florida, meanwhile, scammers have been traveling door-to-door, asking whether individuals currently have health insurance. If not, some individuals have reportedly been threatened with prison time if they do not sign up for coverage on the spot…[69]

With an influx of Navigators, Assisters, and individuals employed by non-governmental organizations like Enroll America engaging in ObamaCare outreach, it will be very difficult for consumers to differentiate between a scam artist and a legitimate source of information. In a July 2013 news article entitled *Feds: Beware of 'ObamaCare' scams as fraudsters prey on confusion*, Lois Greisman, associate director for the Federal Trade Commission's division of marketing practices, stated that "[ObamaCare] is the huge, new government program. There's no doubt in my mind that the fraudsters view it as an opportunity to rip people off."[70] When questioned about the article during her transcribed interview, Ms. Gottlich shared the concern that fraudsters will pose as Navigators or Assisters and try to steal consumer information:

> Q: Have you heard about some of the scams mentioned in the [July 2013] article?
>
> A: Yes.

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[66] *Id.*
[67] Lindsay Wise, *Feds: Beware of 'ObamaCare' Scams as Fraudsters Prey on Confusion*, NewsObserver.com (July 12, 2013), *available at* http://www.newsobserver.com/2013/07/12/3026645/feds-beware-of-ObamaCare-scams.html.
[68] J.D. Harrison, *Using ObamaCare as bait, scam artists target consumers and business owners*, THE WASHINGTON POST (Sept. 10, 2013) *available at* http://www.washingtonpost.com/business/on-small-business/using-ObamaCare-as-bait-scam-artists-target-consumers-and-business-owners/2013/09/10/27a4ca36-1a1b-11e3-82ef-a059e54c49d0_story.html.
[69] *Id.*
[70] Lindsay Wise, *Feds: Beware of 'ObamaCare' Scams as Fraudsters Prey on Confusion*, NewsObserver.com (July 12, 2013), *available at* http://www.newsobserver.com/2013/07/12/3026645/feds-beware-of-ObamaCare-scams.html.

Q: Okay. And does this cause concern for your Department?

A: Yes.

Q: Okay. And another line…reads, "The FTC received more than 1,100 complaints about similar scams in May alone." And it seems to suggest that the scams will only continue or increase as we approach October 1st implementation. Is that something that you're concerned about?

A: Yes.

Q: Okay. And are you concerned that people will pose as Navigators and try to take consumer information?

A: Yes.[71]

Despite her concerns, Ms. Gottlich was unable to articulate how HHS's protocols would protect consumers against unscrupulous Navigators and Assisters or fraudsters posing as Navigators or Assisters. To date, HHS has not taken necessary actions to protect citizens from scam artists trying to take advantage of confusion about ObamaCare. HHS issued only a single page of guidance for consumers, and this guidance failed to address multiple scenarios where scammers could impersonate Navigators and steal information.[72] Moreover, most Americans will not know where to access a relevant fact sheet even if the fact sheet contained useful information. Furthermore, HHS has not instituted protocols to better protect consumers from identity theft through the misuse of information on paper applications or information stored on hard drives of Navigator computers.

During Ms. Gottlich's testimony, she stated that Navigator and Assister organizations will be listed on the HHS website so that consumers can cross check the Navigator organization with the website.[73] However, because HHS will not maintain a list of names of certified Navigator and Assister personnel, she admitted that there is no way for consumers to verify whether a person is affiliated with a legitimate organization.[74] In fact, HHS will be unable to confirm if the individual contacting the consumer is a legitimate Navigator or Assister for consumers who call the HHS hotline recommended on the HHS Consumer Information Sheet. As discussed earlier, CMS contemplated creating a list of all individuals certified and authenticated as Navigators and Assisters but ultimately decided not to create such a list.[75]

Moreover, Ms. Gottlich added that Navigators and Assisters will not be given official badges or other forms of identification or documents because scam artists could recreate official looking documents to fool consumers anyway:

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[71] *See* GOTTLICH INTERVIEW, *supra* note 25.
[72] *Protect Yourself from Fraud in the Health Insurance Marketplace*, CMS Product No. 11693, Dept. of Health & Human Serv., Aug. 2013, *available at* https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/.
[73] *Id.*
[74] *See* COHEN INTERVIEW, *supra* note 1; *See* GOTTLICH INTERVIEW, *supra* note 25.
[75] Memo from Vicki Gottlich to Gary Cohen, May 28, 2013 (on file with Committee).

> Q: So will the Navigators and Assisters be required to carry their certificate with them or have a badge of some sort?
>
> A: There won't be a badge. And we're actually discussing now how are you going to show [that] I'm a bona fide navigator. And if you think about it, and you think about the scams and you think about the scams that have occurred in the past with Medicare, there were a lot of very official looking documents that went out that weren't necessarily Federal Government documents. So we're trying to work that out.[76]

Contrary to Ms. Gottlich's testimony, the HHS Consumer Information Sheet advises consumers to look for "official government seals, logos or web addresses" to help determine if the information presented by a Navigator or Assister is legitimate.[77] It is troubling that HHS would provide this information to consumers a month after Ms. Gottlich, the senior CCIIO official in charge of the Navigator and Assister program until June 2013, testified that scam artists can easily reproduce official looking documents and seals. Moreover, the fact sheets being developed by HHS are an inadequate solution to a serious problem since the vast majority of Americans will not know where and how to locate this information.

During her transcribed interview, Ms. Gottlich also testified that Navigators and Assisters would not be permitted to use personal laptops to sign people up for ObamaCare, but would rather use laptops purchased by Navigator or Assister entities.[78] However, a whistleblower inside CMS has warned that computers provided by Navigator entities pose problems as well because it may not be possible to track each computer and hard drive containing the personally identifiable information of applicants. The CMS whistleblower has also warned that Navigators and Assisters will sometimes scan supporting documentation for eligibility determinations, with scanners storing images containing PII.

Adding to the problems with the ObamaCare outreach campaign is the Administration's lack of clarity about acceptable and unacceptable Navigator marketing practices. A 2009 Government Accountability Office (GAO) report found that inappropriate marketing techniques were used to encourage people to sign up for Medicare Advantage, including door-to-door solicitation and giving gifts of more than nominal value.[79] When asked about these two practices, Ms. Gottlich assured Committee staff that neither type of activity would be performed by Navigators or Assisters:

> Q: So door-to-door marketing without an appointment was considered an inappropriate practice by GAO?

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[76] *See* GOTTLICH INTERVIEW, *supra* note 25.

[77] *Protect Yourself from Fraud in the Health Insurance Marketplace*, CMS Product No. 11693, Dept. of Health & Human Serv., Aug. 2013, *available at* https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/.

[78] *See* GOTTLICH INTERVIEW, *supra* note 25.

[79] Medicare Advantage: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue, Government Accountability Office, December 2009, *available at* http://www.gao.gov/assets/300/299560.pdf.

A: Yes, same thing for Navigators and Assisters.

...

Q: So if somebody comes to your door without an appointment, that is, that's a fraud.

A: Yes, that's correct.

Q: One other thing they [GAO] mentioned was that providing potential enrollees with meals or gifts of more than nominal value to induce enrollment was considered inappropriate.

A: Yes. Same thing for Navigators.

Q: Okay. So if they have, you know, a table at a fair, and they're, like, you know, if you come and make an appointment with us, we'll give you a coupon to whatever, that's not going to be allowed.

A: I believe that's correct.[80]

Despite Ms. Gottlich's repeated insistence that Navigators and Assisters would not be allowed to canvass door-to-door, make unsolicited phone calls, or send unsolicited emails, HHS's Consumer Information Sheet failed to include this information.[81] Mr. Cohen had the following exchange with Committee staff regarding solicitation for ObamaCare:

Q: Would it be inappropriate for Navigators and Assisters to go door to door to find potential applicants?

A: So we have had discussion about door to door and about concerns about problems that can arise from people going door to door and in particular actually the biggest concern that has been expressed to me has been that we should just tell people -- well, that people who could not really be Navigators but say they were Navigators could be going door to door, and one way to prevent that is just to say, we don't go door to door, and then you don't have that problem.

I think that conversation is still happening, but it is certainly an issue that we are conscious of and are thinking about, whether we would give it direction.

Q: So 2 weeks ago, Vicki [Gottlich] told us that Navigators and Assisters would not be doing door to door, but you are saying that [discussion] is still ongoing?

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[80] *See* GOTTLICH INTERVIEW, *supra* note 25.

[81] *Protect Yourself from Fraud in the Health Insurance Marketplace*, CMS Product No. 11693, Dept. of Health & Human Serv., Aug. 2013, *available at* https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/.

A: She may be ahead of me on the policy, honestly.

Q: Is that something you could follow up with us on?

A: Yes. Fair question.

Q: Same question about going door to door, except for calling individuals [with] unsolicited phone calls. So do you think [making unsolicited phone calls] would be inappropriate for Navigators and Assisters?

A: I don't have an answer for you on that, but the same, I will go back and talk to our folks and see if anyone can answer. It is a fair question.

....

Q: For the normal person, how are they going to be able to identify legitimate individuals giving them information about the Affordable Care Act from individuals who are not?

A: So I think that, I think that Navigator grantees, the organizations, and Assister entities ... have some ability to determine ... what sort of identifying -- identifications they are going to provide to the people who are doing the work.

I think that, as we have talked about, assuming that and I think a fair assumption that Vicki [Gottlich] is right and ultimately we are going to be saying no one is going to be going door to door, then that makes it a little easier, right, because it is not like someone is coming up to your door saying, I'm a Navigator. You are seeing them in a location that it is either at a meeting or they have got a kiosk in the mall or that kind of thing. I think that we are going to encourage people in the first instance to contact the organization that the person is saying that they are affiliated with if they want confirmation that this person actually is representing that organization and is authorized to do the work rather than contact us.

Q: There might be a problem with someone not providing the legitimate organization that they are representing?

A: That is true, and that information will be available online and through the call center as to what the organizations are.

Q: So this fact sheet is going to come out, and it will clarify what are appropriate marketing practices for Navigators and Assisters and what is inappropriate?

A: I think that is right. That is the draft I have seen addresses those issues.

Q: So we are likely to be able to tell Americans, if there are news stories of someone coming to their door or calling them on the phone, then they should not deal with that individual?

A: I believe that is right.[82]

Despite both Ms. Gottlich's and Mr. Cohen's statements about direct solicitation and gifts of nominal value, as of August 29, 2013, HHS has not yet formulated official guidance on either.[83] No one within the Administration has yet provided the clarity of Michael Flagg, Director of Communications for the District of Columbia's Department of Insurance, Securities and Banking, who was quoted by the *Washington Post* as saying "If somebody calls and offers to sign you up [for ObamaCare] for $500, whether you're a business owner or individual consumer, you just have to hang up."[84] It is now seven weeks after Mr. Cohen's transcribed interview, and HHS has still not provided definitive answers to the Committee's questions about direct solicitation and gifts of nominal value despite Mr. Cohen's agreement to do so during his August 7, 2013, interview. In response to the Committee's latest request for documents, HHS staff emailed Committee staff on August 29, 2013:

> CMS is currently working on a document addressing door to door marketing. It is a follow up to the program integrity final rule that was released yesterday and covers issues having to do with providing personalized assistance. It should be out soon. We're still looking into the issue of nominal gifts.[85]

It is troubling that HHS is formulating guidelines for basic Navigator and Assister marketing practices only a month before open enrollment, and weeks after Navigator and Assister grants have been awarded and training materials have been finalized.

The Administration's confusion about the basic tenets of the outreach program extends not only to marketing techniques but also to methods of enrollment, such as the use of paper applications for ObamaCare. Ms. Gottlich stated in her transcribed interview that Navigators will generally not be giving out paper applications and that over 99 percent of applications will be online:

> Q: So navigators cannot leave someone with their information on a paper application.
>
> A: That's going to be our standard -- you know, there -- it's hard to say, yes and no. I mean, 99.99 percent of the time there's going to be no paper applications. You know. Navigators are not going to be completing paper applications. Navigators are going to be doing all the applications online.[86]

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[82] *See* COHEN INTERVIEW, *supra* note 1.
[83] Email from Centers for Medicare and Medicaid Services, Dept. of Health & Human Serv. and Committee staff (August 29, 2013) (on file with Committee); The Committee requested documents related to Navigator and Assister marketing practices from HHS in its original May 6th document request, and this request was reiterated to HHS officials multiple times.
[84] *Id.*
[85] Email from Centers for Medicare and Medicaid Services, Dept. of Health & Human Serv. and Committee staff (August 29, 2013) (on file with Committee).
[86] *See* GOTTLICH INTERVIEW, *supra* 25.

However, weeks later, Mr. Cohen stated the opposite in his interview with Committee staff:

> Q: Are Navigators and Assisters going to be providing, or are they allowed to provide, applicants with paper applications?
>
> A: Yes.[87]

However, Mr. Cohen and Ms. Gottlich agreed that Navigators and Assisters will be allowed to type an applicant's information into the online applications system.[88] Committee staff asked Mr. Cohen about the distinction between typing in applicant information and actually enrolling someone, which Navigators and Assisters are not permitted to do. Mr. Cohen responded that "enrolling encompasses the decision, the choice to become enrolled in a health plan. I don't think the physical activity of inputting the information on a form or online is enrollment."[89]

As it turns out, and as confirmed by the contractor Serco,[90] the expectation is that millions of paper applications will need to be processed in the next few months.[91] Navigators and Assisters' roles in assisting with paper applications creates increased data security risks because consumers might trust persons posing as Navigators and Assisters to mail an application on their behalf, or make copies of the application, which contain a plethora of PII. It is alarming that at the time of her testimony and at the time when HHS was considering policies governing Navigator and Assister activities, Ms. Gottlich, the federal official in charge of the Navigator and Assister program until June 2013, was unaware of the expectation that Navigators and Assisters will handle an enormous number of paper applications.

V. High Risk that Navigators and Assisters Will Not Be Fair and Impartial

Section 1311 of PPACA requires that Navigators "distribute fair and impartial information."[92] However, HHS has failed to define what "fair and impartial information" means in the context of consumer outreach for ObamaCare. According to testimony from Ms. Gottlich and Mr. Cohen, no independent entity determined what information Navigators and Assisters must provide to consumers or how that information would be represented.[93] Ms. Gottlich stated that she believed "impartial and fair means explaining the full range of [consumer] options," and

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[87] *See* COHEN INTERVIEW, *supra* 1.
[88] *Id.*; *See* GOTTLICH INTERVIEW, *supra* note 25.
[89] *See* COHEN INTERVIEW, *supra* 1
[90] Sarah Kliff, *Meet Serco, the private firm getting $1.2 billion to process your ObamaCare application*, WASHINGTON POST, July 16, 2013, *available at* http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/16/meet-serco-the-private-firm-getting-1-2-billion-to-process-your-ObamaCare-application/.
[91] Senior employees of Serco, a contractor awarded a contract to process ObamaCare applications, told the Committee that paper applications in federal exchanges are expected to comprise as much as one-third of the total volume of applications. Oversight & Government Reform Staff Meeting with Serco Officials regarding HHS Contract (Aug. 14, 2013).
[92] Pub. L. No. 111-148, Sec. 1311.
[93] *See* GOTTLICH INTERVIEW, *supra* 25.

that full range of options would be included in the Navigator training.[94] As a result, those crafting the Navigator training – HHS officials, particularly those within HHS's Office of Communications, and government contractors at Booz Allen Hamilton – had sole discretion over how to portray ObamaCare to millions of Americans. In addition to concerns that the Administration will determine what constitutes "fair and impartial" ObamaCare information, Navigators and Assisters are likely to promulgate misinformation due to inadequate training and the incentives in place to maximize enrollment.

Problematic Pay-Per-Enrollee Payment Structure

Navigators and Assisters in some states will be paid depending on how many persons they enroll in ObamaCare.[95] With this kind of pay structure, Navigators and Assisters have a financial incentive to persuade people to enroll. Ms. Gottlich admitted that paying Navigators for each person they enroll could lead Navigators and Assisters to cross the line from simply "facilitating" enrollment, to persuading persons to enroll and/or actually enrolling them.[96] When asked about this pay structure in her transcribed interview, Ms. Gottlich stated that she recognized an inherent conflict of interest in her personal capacity:

> Q: So you personally recognize the conflict of interest between providing fair and impartial information and also paying Navigators based on how many people are enrolled?
>
> A: Well, you know, they can still provide fair and impartial information.
>
> Q: I agree. But there's a conflict of interest.
>
> A: There could be.[97]

Mr. Cohen also admitted Navigators have an incentive to enroll more individuals when they are paid per enrollee.[98] When asked if that payment structure incentivized Navigators to enroll people, Mr. Cohen responded in the affirmative and suggested that despite the law's prohibition on Navigators and Assisters enrolling individuals in ObamaCare, they will be incentivized to do exactly that.

> Q: So do you recognize that paying an individual based on whether they enroll someone provides an incentive for them to try to enroll that person?
>
> A: Yes, but that is an incentive I think they have. That is the nature of the job, you know. That is what Navigators are supposed to be doing, helping people.[99]

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[94] *Id.*
[95] ASSISTERS PROGRAM: IN-PERSON ASSISTANCE AND NAVIGATOR STAKEHOLDER WEBINAR, California Health Benefit Exchange, March 14, 2013, *available at* http://www.healthexchange.ca.gov/StakeHolders/Documents/Assisters2ndWebinar%20March14-2013_FINAL.pdf.
[96] *See* GOTTLICH INTERVIEW, *supra* 25.
[97] *Id.*
[98] *See* COHEN INTERVIEW, *supra* note 1.
[99] *Id.*

Mr. Cohen's response presupposes that everyone targeted by a Navigator or Assister will be helped by signing up for ObamaCare, which is certainly not true given how much ObamaCare increases premiums for relatively young and healthy individuals and reduces choices in many state insurance markets.[100] When Navigators or Assisters are incentivized to increase enrollment, they will be less concerned with providing fair and impartial information and more concerned with persuading individuals to enroll.

Mr. Cohen testified that he believed, but was not certain, that HHS had prohibited Navigator organizations in federal exchanges, from paying their employees based on enrollment.[101] Although Assisters in state-based exchanges are being financed with federal tax dollars, HHS has refused to prohibit Assister organizations from paying their employees based on enrollment. Mr. Cohen did not explain why HHS would eliminate this conflict of interest for Navigators in federal exchanges while allowing the conflict of interest to remain for Navigators and Assisters in state-based exchanges.

> Q: Are you concerned that paying Navigators and Assisters based on how many people they enroll will lead some Navigators and Assisters to pressure individuals to enroll?
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> A: I think all I can say is that if I am correct, we made a determination for the Federally Facilitated Marketplace that we would not permit that, but we have given states flexibility to do it differently, and I respect their decision to do it differently if that is what they think is the best thing for their particular situation.[102]

Compounding the problem of the payment structure is that the Administration is not requiring that Navigators and Assisters who are paid per enrollee disclose that fact to individuals with whom they interact. Ms. Gottlich testified that Navigators and Assisters are required to disclose conflicts of interest to applicants, such as a relationship the Navigator or Assister has with a health insurer, but that there will not be a standard disclosure and "the individual grant entity [will] determine how that information should be disclosed."[103] Ms. Gottlich testified that Navigators and Assisters will **not** be required to disclose to individuals if they are paid based on how many people they enroll.[104] Mr. Cohen was unsure whether there was a standard disclosure requirement for Navigators and Assisters:

> I don't believe, in the Federal facilitated marketplace, we are going to be compensating based on the number of people enrolled. I have heard that there are states, state-based marketplaces that are doing that, and I would

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[100] Chris Conover, *Young People Under ObamaCare: Cash Cow For Older Workers*, FORBES (Nov. 27, 2013), http://www.forbes.com/sites/chrisconover/2012/11/27/young-people-under-ObamaCare-cash-cow-for-older-workers/.

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[102] *See* COHEN INTERVIEW, *supra* note 1.

[103] *See* GOTTLICH INTERVIEW, *supra* 25.

[104] *Id.*

think it would be up to them to determine whether that disclosure would be required.[105]

In a list of clarifying questions following Mr. Cohen's interview, the Committee asked HHS to explain whether Navigators in federal exchanges could be compensated based on how many people they enroll. Five weeks later, HHS has yet to provide a response.[106]

Insufficient Navigator Training Standards

HHS is ultimately responsible for developing and operating the training program which will prepare both Navigators and Assisters to provide information to consumers about ObamaCare and factors related to health insurance.[107] The online training for Navigators and Assisters consists of multiple informational modules with each module followed by an open-book exam module. Individuals can complete the training using personal computers. Prior to the training being released, HHS estimated that it would take between 20 and 30 hours to complete the online training.[108] However, the actual training program states that it will only "provide approximately 5-20 hours of training."[109]

The online training materials were released publicly on August 29, 2013, allowing Navigators and Assisters just over a month to register and complete the training before the exchanges open on October 1, 2013, and leaving little time for any substantive or technical glitches to be corrected. As of July 27, 2013, and August 7, 2013, the dates of their respective interviews, neither Ms. Gottlich nor Mr. Cohen, the head of the HHS department overseeing the Navigator and Assister programs, had even seen a draft version of the Navigator training and both did not know when the training would be completed.[110] Moreover, according to Mr. Cohen, no one in the legislative branch was allowed to review the training prior to its public release, nor were any independent parties allowed to review the training for fairness and impartiality.[111]

While each Navigator and Assister must create an online account with a login and password to access the training modules, it will be easy for a person other than the one who created the account to take the training. In fact, anyone could complete the exams once the person has logged into the training. It would also be possible for individuals to collaborate on exam questions. Moreover, while a Navigator must score above 80 percent on each exam to pass a particular module, there is no limit to how many times a Navigator may take each exam.

During their transcribed interviews, both Mr. Cohen and Ms. Gottlich expressed uncertainty around the development and oversight of the training. For example, Mr. Cohen testified that Ms. Gottlich "is the person within CCIIO who has the greatest responsibility with

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[105] *See* COHEN INTERVIEW, *supra* 1.
[106] Email from Committee staff to Centers for Medicare and Medicaid Services, Dept. of Health & Human Serv. staff (August 22, 2013) (on file with Committee).
[107] *See* BRIEFING, *supra* 12.
[108] *Id.*
[109] Navigator Training Overview, Navigator Online Training, *available at* https://marketplace.medicarelearningnetworklms.com/Default.aspx (last visited Sept. 10, 2013).
[110] *See* GOTTLICH INTERVIEW, *supra* note 25; *see* COHEN INTERVIEW, *supra* note 1.
[111] *See* GOTTLICH INTERVIEW, *supra* note 25.

respect to developing the training,"[112] yet Ms. Gottlich told Committee staff on July 25, 2013, that she stopped overseeing preparation of the training in June of 2013.

> Q: Are you responsible for the training?
>
> A: I am not responsible for training now. The Office of Communications is now in charge of all the training. ...
>
> Q: The training for what?
>
> A: For everybody. For navigators, non-navigator assistance personnel, call center. That change happened in June after we spoke in April.
>
> Q: After June. So they're responsible for the modules?
>
> A: They're responsible for the modules, yes.[113]

Surprisingly, Mr. Cohen stated that it would be "logical" for Navigators and Assisters to conduct outreach activities *prior to* completing the training[114] even though HHS is operating under the assumption that most individuals hired as Navigators and Assisters will lack experience with health insurance markets and ObamaCare.[115] As a result of their lack of knowledge and their inexperience, Navigators and Assisters will face a significant learning curve in order to provide accurate and unbiased information about an extremely complicated matter to consumers within a few weeks of being hired. Without adequate training, it is likely that many Navigators and Assisters will confuse and mislead consumers regardless of how Navigators and Assisters are paid. Furthermore, unlike agents and brokers, Navigators and Assisters bear no personal liability if they give taxpayers misinformation that damages their financial interests.

Despite Mr. Cohen's claim that he thinks "there will be information that will be required to be provided" by Navigators and Assisters, HHS has not been able to provide the Committee with a list of all the information that Navigators and Assisters will be required to tell potential applicants. According to Mr. Cohen, Navigators and Assisters will primarily be answering questions from individuals:

> [T]here will also be information that is going to depend on what the person asks. And if the person doesn't ask about it, then the Navigator or Assister most likely wouldn't provide that information because it wouldn't be relevant to that person.[116]

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[112] *See* COHEN INTERVIEW, *supra* note 1.
[113] *See* GOTTLICH INTERVIEW, *supra* note 25.
[114] *See* COHEN INTERVIEW, *supra* note 1.
[115] *See* BRIEFING, *supra* note 12.
[116] *See* COHEN INTERVIEW, *supra* note 1.

Mr. Cohen testified that Navigators will likely not provide information on the requirement to purchase insurance, the relatively small individual mandate penalty, or the exceptions to the individual mandate penalties unless prompted by the consumer.[117] Failure to explicitly provide information related to the individual mandate indicates that Navigators and Assisters will not provide fair and impartial information since it is important for individuals to receive information related to the individual mandate to determine how to best satisfy their legal obligation to obtain coverage, given their own specific circumstances.[118] Without a clear requirement to provide information about the size of the mandate penalty and the numerous exemptions to the mandate, Navigators and Assisters may decide to withhold this information from individuals in order to encourage enrollment. This could result in consumers making suboptimal decisions, such as purchasing coverage that they cannot afford, or paying a penalty when exemptions might be available.

VI. Time-Crunched States Unable to Take Actions to Regulate Navigators and Assisters

Several states have expressed concerns to Secretary Sebelius and HHS about the inadequacy of federal guidelines and requirements for Navigators and Assisters. In a detailed letter dated August 14, 2013, thirteen state Attorneys General (AGs) wrote Secretary Sebelius with their concerns over insufficient training standards, consumer protections, and fraud prevention mechanisms related to the ObamaCare outreach campaign.[119] HHS has yet to provide any response to their concerns or questions, and the lack of response from HHS exacerbates the Committee's ongoing concerns about the Administration's implementation of ObamaCare.

The AGs' letter echoed many of the same concerns raised by many on the Committee, including the failure of HHS to require uniform criminal background checks or fingerprint requirements for those hired to perform ObamaCare outreach and the Administration's decision to significantly reduce training requirements for Navigators and Assisters.[120] The AGs' letter also refers to HHS's proposed consumer safeguards for Navigators and Assisters as "woefully substandard," particularly when compared to the licensure and liability requirements of health insurance agents and brokers, and to the required background checks of census workers, and federal workers who conduct similar outreach activities.[121] The AGs write that these consumer outreach initiatives are "a privacy disaster waiting to happen" because lax screening and supervision means that individuals "will have easy means to commit identify theft on consumers seeking enrollment assistance."[122]

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[117] *Id.*
[118] Pub. L. No. 111-148, Sec. 1501.
[119] *See* letter from Patrick Morrisey, West Virginia AG, James D. "Buddy" Caldwell, Louisiana AG, Luther Strange, Alabama AG, Bill Schuette, Michigan AG, Pamela Jo Bondi, Florida AG, Tim Fox, Montana AG, Samuel S. Olens, Georgia AG, Jon Bruning , Nebraska AG, Derek Schmidt, Kansas AG, Wayne Stenehjem, North Dakota AG, E. Scott Pruitt, Oklahoma AG, Greg Abbott, Texas AG and Alan Wilson, South Carolina AG, to the Honorable Kathleen Sebelius, Secretary, Dep't of Health and Human Services, (Aug. 14, 2013).
[120] *Id.*
[121] *Id.*
[122] *Id.*

More than a dozen states have imposed or are considering legislation to protect their citizens from the risks posed by unscrupulous or poorly trained Navigators and Assisters or individuals posing as Navigators and Assisters.[123] For instance, Florida passed a law earlier this year that requires Navigators to be fingerprinted and have background checks conducted by the Florida Department of Law Enforcement.[124] Despite initial resistance, California decided to require background checks and fingerprinting for its Assisters as well.[125] Navigators in Montana are also required to be fingerprinted, pass a background check, and receive special training on Montana privacy laws in order to gain certification.[126]

Many states are concerned about HHS's failure to provide specific guidance about whether these steps preempt federal law. Mr. Cohen and Ms. Gottlich were both unable to provide specific answers when asked whether HHS had clearly defined what legislative requirements states are allowed to impose to minimize the risk of fraud and misinformation. Ms. Gottlich said that HHS has not "nullified anything that a State has done"[127] so far; however, Mr. Cohen said that HHS is actively following "the activity in State legislatures to see what they were doing...."[128] In his transcribed interview, Mr. Cohen testified:

> So I think that, you know, the states have flexibility to impose additional requirements on Navigators when they are the granting agency. And the general preemption provision in the Affordable Care Act, which says that states can -- you know, that State laws are not preempted unless they prevent the implementation of the Affordable Care Act, would apply to those types of provisions. And it would really be a legal, you know, determination, not mine, whether any particular State requirement...[129]

Recalling a conversation he had with the Iowa State Insurance Commissioner, Mr. Cohen testified "[w]e've regulated, we've said that states may not require Navigators to be licensed as insurance agents or brokers...."[130] However, when asked about licensure of Navigators more generally, Ms. Gottlich responded "[l]icensing and certification wouldn't be a problem. But on the issue would come what's the cost of the licensing and certification...."[131] Ohio,[132]

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[123] Katie Keith and Kevin Lucia, the Commonwealth Fund, *Will New Laws in States with Federally Run Health Insurance Marketplaces Hinder Outreach?* (July 1, 2013), *available at* http://www.commonwealthfund.org/Blog/2013/Jul/Will-State-Laws-Hinder-Federal-Marketplaces-Outreach.aspx.

[124] Zachary Fagenson & Bill Cotterell, *Florida Voices Privacy concerns over ObamaCare 'Navigators,'* REUTERS, Aug. 20, 2013, *available at* http://www.reuters.com/article/2013/08/20/us-usa-florida-healthcare-idUSBRE97J0XK20130820.

[125] Covered California Certified Enrollment Counselors, available at *http://www.cahba.com/covered-california/assisters.htm.*

[126] Dan Boyce, *Insurance Commissioner seeks to dismiss fears of privacy infringement from ObamaCare*, Montana Public Radio, Aug. 27, 2013, *available at* http://mtpr.org/post/insurance-commissioner-seeks-dismiss-fears-privacy-infringement-ObamaCare.

[127] *See* GOTTLICH INTERVIEW, *supra* note 25.

[128] *See* COHEN INTERVIEW, *supra* note 1.

[129] *Id.* at 34.

[130] *Id.*

[131] *See* GOTTLICH INTERVIEW, *supra* note 25.

[132] Sandhya Somashekhar, *States Fine New Ways to Resist Health Law*, WASHINGTON POST, Aug. 28, 2013, *available at* http://www.washingtonpost.com/national/health-science/states-find-new-ways-to-resist-health-law/2013/08/28/c63f8498-0a93-11e3-8974-f97ab3b3c677_story.html.

Missouri,[133] Iowa,[134] Montana,[135] and perhaps other states have already acted to require some type of certification for Navigators.

HHS-Approved Actions States Can Take to Minimize the Risk of Fraud and Misinformation

Although HHS has refused to directly provide states with information about the types of actions they can take to minimize the risk of fraud and misinformation from poorly trained Navigators and Assisters and scam artists, the Committee has learned that there are two specific actions that are allowed. First, the Committee has learned that states can require Navigators and Assisters to pass a background check and be fingerprinted.[136] Second, given the lax education and training standards, many states are understandably concerned that Navigators and Assisters will not adequately understand either ObamaCare, health insurance or the necessary protections for sensitive consumer information. The Committee has learned that states can design their own additional tests and require that Navigators and Assisters pass these tests as a condition of employment.[137] These tests would overcome the problem of Navigators completing the training and becoming certified without adequately learning the information necessary to inform consumers about the benefits and costs of signing up for coverage through ObamaCare. Finally, given the poor design of the Navigator and Assister programs, states should consider alerting their populations to the risk posed by individuals directly soliciting them about ObamaCare.

VII. Conclusion

When ObamaCare was being debated by Congress, then-Speaker Nancy Pelosi famously stated that "We need to pass the bill so you can find out what's in it."[138] Three-and-a-half years later and after Americans have learned more about the law, ObamaCare remains deeply unpopular. ObamaCare's individual mandate, employer mandate and new taxes will result in dramatically higher premiums for young Americans. The law also offers unsustainable and expensive subsidies to individuals to disguise the visible component of ObamaCare's rising premiums and pass an increasing burden to taxpayers. Navigator and Assister programs are aiming to sign up enough young and healthy people so that the law's Rube Goldberg structure does not collapse.

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[133] Virginia Young, *New Missouri Law Imposes Hurdle for Insurance Exchange*, St. Louis Post, July 17, 2013, *available at* http://www.stltoday.com/news/local/govt-and-politics/political-fix/new-missouri-law-imposes-hurdle-for-insurance-exchange/article_dccc78f9-6171-5350-a84a-2a263a5f9db7.html.

[134] *Iowa passes insurance navigator legislation*, June 4, 2012, *available at* http://www.onlinenavigator.org/news/Iowa-passes-insurance-navigator-legislation.html.

[135] Dan Boyce, *Insurance Commissioner seeks to dismiss fears of privacy infringement from ObamaCare*, Montana Public Radio, Aug. 27, 2013, *available at* http://mtpr.org/post/insurance-commissioner-seeks-dismiss-fears-privacy-infringement-ObamaCare.

[136] *See* COHEN INTERVIEW, *supra* note 1.

[137] *See* GOTTLICH INTERVIEW, *supra* note 25.

[138] Peter Roff, *Pelosi: Pass Health Reform So You Can Find Out What's In It*, U.S. NEWS (Mar. 9, 2010), http://www.usnews.com/opinion/blogs/peter-roff/2010/03/09/pelosi-pass-health-reform-so-you-can-find-out-whats-in-it.

In order to increase enrollment, the Administration has decided to spend hundreds of millions of dollars in an extralegal attempt to increase enrollment through the Navigator and Assister programs. The Committee has previously raised concerns with the outreach campaign. Despite several Committee members' common sense recommendations, the training to be Navigators and Assisters will last only five to 20 hours and there is no requirement for a background check of Navigators and Assisters who will have access to highly sensitive personal information, such as Social Security numbers, dates of birth, and income for everyone in an applicant's household. Given the stories about how scammers are gearing up to take advantage of the tremendous confusion caused by ObamaCare, Americans are at an increased risk of being the victim of fraud and identify theft because of the Administration's poor development of its outreach programs. Moreover, allowing Navigators and Assisters to be paid on a per enrollee basis, without even requiring that the Navigator or Assister disclose his or her financial interest in increasing enrollment, means Navigators and Assisters will have the incentive to provide false or misleading information to maximize enrollment. The Committee's preliminary findings indicate that Americans should approach the information provided by Navigator or Assisters with caution, at least until the Administration reforms the outreach program and addresses the many limitations discussed in this report.

Statement of Congressman Gerald E. Connolly (VA-11)
Committee on Oversight and Government Reform
Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs &
Subcommittee on Energy Policy, Health Care, and Entitlements
Federal Implementation of ObamaCare: Concerns of State Governments
September 18, 2013

Today's joint hearing exemplifies the majority's troubling and routine abuse of this Committee's oversight authority to conduct tired political theater that attacks the Patient Protection and Affordable Care Act to advance partisan aims – yet doing nothing to strengthen public policy, or provide affordable, quality health care coverage to millions of uninsured Americans.

Ensuring our Nation develops an effective and efficient healthcare system may be the most important and enduring challenge we face today. This critical issue begs to be addressed in a serious, substantive, and bipartisan manner. Yet time and time again, the Republican majority's blind hatred of the Obama Administration's efforts insure all Americans has led them to waste taxpayer dollars in holding partisan show hearings designed to score political points while pursuing the astonishing goal of preventing American families from obtaining affordable healthcare.

Even with something as simple as today's hearing title, the majority cannot resist imposing a false narrative as if it were fact. Exhibit A. is today's *very* fair and balanced title that simply asserts the existence of conveniently unidentified and vague "…Concerns of State Governments" with implementation of the Affordable Care Act, as if the partisan accusations of a few Republican malcontents constitutes evidence of real national implementation problems.

I hope the press will note that the Republican majority failed to invite a single representative of a nearby neighbor, the State of Maryland – which won an "Early Innovator" grant in recognition of its impressive progress implementing an effective and innovative insurance exchange supported by insurance carriers, hospitals, providers, brokers, advocates, and consumers. Could it be that the majority wants to hide real world examples of effective Affordable Care Act implementation by a popular Democratic governor?

Would it have been that difficult to convene a serious hearing that oversees the implementation of the Affordable Care Act by focusing on challenges *and* successes that provide insights into how we can enhance intergovernmental coordination and collaboration, not simply repeal healthcare reform? Perhaps our press tables would be sparser, yet I would respectfully suggest to my Republican colleagues that this is a slight price to pay in order to achieve intellectual honesty.

As a public servant who spent the majority of my time serving in local government, I am inclined to be sympathetic to concerns of State and local governments with unreasonable Federal mandates. However, I have little patience for those who would use these concerns as a false pretense to launch unfounded and unsubstantiated partisan attacks to foil the Administration's efforts to provide all Americans with quality health insurance.

(OVER)

The utterly hollow nature of Republican "concerns" over Affordable Care Act implementation are laid bare by the stark discrepancy between the spurious allegations and complaints of Republican elected officials who just happen to be outright opposed to the Affordable Care Act, and the positive implementation experience of States such as Minnesota, Oregon, and California. California's experience implementing the Affordable Care Act is particularly worth focusing on, since it is our Nation's largest State, contains 7.1 million uninsured residents, and boasts one of the most robust implementation efforts.

I recognize that facts have proven to be of little interest to my Republican colleagues. Nevertheless, I would point out that in 2009, the Congressional Budget Office projected that a medium-level "silver" plan would cost $5,200 annually on the California exchange, while the actuarial firm Milliman predicted that the average silver plan in California would carry a $450 monthly premium. I am confident that my colleagues in the majority are familiar with these figures, since I recall not too long ago they were waiving them about while peddling Republican talking points that featured dire predictions about "ObamaCare" and the coming "rate shock."

Fortunately, today we no longer need to rely on projections, we can instead check reality. .

Lo and behold, the *actual* average premium for the "silver plan" on California's Affordable Care Act exchange will be $276. Further, for the 2.6 million Californians eligible for Federal subsidies, the premiums will be drastically lower, ranging from an average of $235 for individuals at 150 percent of the Federal Poverty Level (FPL) to $17 for individuals at 300 percent of the FPL. Reality has definitively demonstrated that when a State employs strong insurance regulation, promotes healthy competition, and conducts vigorous outreach, the Affordable Care Act works.

Meanwhile, States such as Louisiana, Kansas, and South Carolina – which are the antithesis of California with respect to preventing Medicaid expansion to cover their lowest-income residents, refusing to establish exchanges, and failing to conduct outreach – have provided their residents with less competition, less choices, and consequently higher premiums relative to proactive States. Perhaps the focus of this hearing should be shifted to overseeing derelict States who are actually harming the welfare of their own residents by maliciously and irresponsibly refusing to implement the law of the land.

One might express shock at such injurious defiance by Republican-governed States, were it not for the relentless efforts of House Republicans to deprive Americans of affordable health insurance coverage by any means necessary, be it outright repeal or backdoor budget cuts. Unfortunately today's joint hearing is neither shocking nor surprising, it merely represents the cynical approach to healthcare policy employed by Republicans that has contributed to Americans losing faith in Congress as an institution.

-END-

Opening Statement
Rep. Michelle Lujan Grisham

Committee on Oversight and Government Reform Subcommittee on Economic Growth, Job Creation and Regulatory Affairs and the Subcommittee on Energy Policy, Health Care and Entitlements joint hearing entitled "Federal Implementation of ObamaCare: Concerns of State Governments"

September 18, 2013

Dr. Colyer, you state in your written testimony that "Uncertainty... is a drag on Kansas businesses... Businesses are scared to invest in jobs, they're scared to invest in expansion..."

I couldn't agree with you more. The Republican's effort to delay, defund, and repeal the Affordable Care Act 41 times without bringing forward any credible alternative for providing health care to our nation's most vulnerable citizens—has created uncertainty for America's businesses.

The Obama Administration, many state governments, businesses, insurers, and the medical community are working toward implementation of the Affordable Care Act. In comparison, House Republicans are currently threatening to shut down the government and let our nation default on its debt unless the ACA is repealed. This uncertainty prevents new hiring and decreases investment and economic growth. The U.S. Chamber of Commerce has stated that,

> *"It is not in the best interest of the U.S. business community or the American people to risk even a brief government shutdown that might trigger disruptive consequences or raise new policy uncertainties washing over the U.S. economy... Likewise, the U.S. Chamber respectfully urges the House of Representatives to raise the debt ceiling in a timely manner and thus eliminate any question of threat to the full faith and credit of the United States government..."*

The Republicans' effort to repeal the Affordable Care Act using artificially-created government funding and debt crises undermines U.S. national interests and jeopardizes the very businesses and jobs that they claim to protect.

But in addition to Republican-sponsored paralysis in Washington, misinformation and misrepresentation regarding the Affordable Care Act are also causing confusion and uncertainty among our nation's citizens. Dr. Colyer, you also state in your testimony that,

> *"...I speak with my colleagues in the medical community every day. To a person all have expressed concern that the law will significantly limit their capacity to practice best care. They don't understand how health outcomes can be improved by a law that drives healthcare decisions to be made from Washington rather than the cherished relationship between the doctor and patient."*

I talk to doctors too, and the idea that the law "drives healthcare decisions to be made from Washington" could not be further from the truth. Doctors want their patients to have access to affordable, quality care and the law actually preserves and expands the private market. In fact, the law's provisions ensure that insurance companies do not jeopardize that sacred relationship by banning insurance companies from placing caps on coverage and turning customers down based on preexisting conditions. That is why many groups that represent physicians, including the American Medical Association, have expressed their support for the law. They don't buy the Republican talking point about bureaucrats coming between doctors and patients, because they know better.

I recently held two town halls about the Affordable Care Act in my district, where I answered questions from my constituents, listened to their concerns, and tried to help them navigate the benefits of the law. I did that because it's my job. As public servants, we should be working to ensure that the ACA is implemented effectively and efficiently, not spreading more uncertainty and misinformation.

Thank you.

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